Perspective of Clients, Providers, Community on Clients' Rights and Responsibilities: SMART Initiatives Formative Research

A consultancy report by

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CHAPTER ONE: INTRODUCTION

OVERVIEW

To improve the quality and use of RH and FP services in Indonesia, STARH assisting the BKKBN, the MOH, and its partners on the communication-support components to act as a catalyst for social change. STARH has developed a communication plan called "the Smart Initiatives" (Smart Client, Smart Provider, and Smart Community).

The objectives of the Smart Initiative are: 1) to improve the quality of interaction between reproductive health providers and clients including clinical/technical performances, technical information exchange, and decision making process; 2) to increase community participation in improving access to and delivery of quality reproductive health services.

The national "Smart" campaign will be launched in April 2002. Formative research was conducted in order to understand how clients, community and providers view quality. This information would be used to help design messages and to action while establishing benchmarks for client and provider perceptions of quality.

OBJECTIVES

To define a dimension of quality based on the clients, community and providers' perspectives through a formative research. These results would benefit STARH to identify the campaign needs.

THEORETICAL FRAMEWORK

Deming notes good quality means "doing the right things right". In family planning quality means offering a range of services that are safe and effective and that satisfy clients' needs and wants. From a public health perspective, quality means offering the greatest health benefits, with the least health risks, to the greatest number of people, given the available resources. Quality may also be defined as meeting minimal standards of care or achieving high standards of excellence. Quality can refer to the technical quality of care; to non-technical aspects of service delivery such as 'clients' waiting time and staff attitudes; and to programmatic elements such as policies, infrastructure, access, and management. Clients, providers, managers, policy-makers, and donors all have differing but legitimate perspective on what constitutes good quality RH/FP care (Population Reports: 3).

From the Smart Patient Client Education Study conducted by STARH, we found that clients who had been coached felt rewarded because providers responded to their questions. Coaching increased client confidence in their ability to speak up.[1] Providers reported client participation was higher during the intervention, and that they were comfortable with higher levels of participation. Coaching clients can empower them to expect good quality care from providers and makes them more effective partners in their own care, and improve the quality of the client-provider interaction.

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1 This finding is consistent with US Studies that found that training patients does change the way they communicate with doctors (as quoted by Kim et al, 2001).

Quality from the providers' perspective:

- ♣ Clinical quality of care (offering technically competent, effective, safe care that contributes to an individual's well being
- ♣ Support services (logistics and record keeping) are also important to the quality of service delivery

Quality from the clients' perspective

- ♣ Highly subjective element includes obtaining the service/supplies they want, waiting time, privacy, ease of access to care, respect, relevant information, and fairness.

Quality from the community leaders' perspective

- ♣ The involvement of community and local social institutions in setting norms
- ♣ The contribution of the community or social network on the making of informed choices and effective users of FP services

CLIENT

SMART COMMUNITY

QUALITY

COMMUNITY LEADER *PROVIDERS*

METHODOLOGY

Data collection was conducted using Focus Group Discussion and In-depth Interview techniques. Three types of groups were involved in the study:

Groups of providers

Group of clients

Group of community leaders (power structure leaders)

LOCATION AND SAMPLE

The study was conducted in selected rural and urban areas in two provinces: Lampung (Kabupaten Metro) and West Java (Kabupaten Kuningan). Within each province, two rural Kecamatans in one Kabupaten and one urban Kecamatan in another Kota were selected based on experience in previous studies.

A total of nine FGDs, with about 6 to 8 women client participants per group, were conducted in two districts: four groups in rural and two groups in urban area.

A total of nine FGDs with providers will be conducted in the same district where the client's FGDs take place.

A total of nine FGDs with community leaders will be conducted in the same district where the client and provider's FGDs take place.

Nine individual in-depth interviews were conducted at each Kabupaten for complementary data.

Table 1. Number of FGDs and In-depth Interviews in each location

Province Location	**Lampung**	**West Java**
Urban *Kecamatan*	1 FGD with clients 1 FGD with providers 1 FGD community leaders 1 in-depth interview with a client 1 in-depth interview with a provider 1 in-depth interview with a community leader	1 FGD with clients 1 FGD with providers 1 FGD community leaders 1 in-depth interview with a client 1 in-depth interview with a provider 1 in-depth interview with a community leader
Mix urban-rural *kecamatan*	1 FGD with clients 1 FGD with providers 1 FGD community leaders 1 in-depth interview with a client 1 in-depth interview with a provider 1 in-depth interview with a community leader	1 FGD with clients 1 FGD with providers 1 FGD community leaders 1 in-depth interview with a client 1 in-depth interview with a provider 1 in-depth interview with a community leader
Rural *Kecamatan*	1 FGD with clients 1 FGD with providers 1 FGD community leaders 1 in-depth interview with a client 1 in-depth interview with a provider 1 in-depth interview with a community leader	1 FGD with clients 1 FGD with providers 1 FGD community leaders 1 in-depth interview with a client 1 in-depth interview with a provider 1 in-depth interview with a community leader
Total number of FGDs	9 FGDs in Lampung 9 in-depth interviews	9 FGDs in West Java 9 in-depth interviews

Qualifications of participants

To make ease the selection of participants we made some qualifications to them.

Client:

- Using modern family planning methods (IUD acceptors and non-IUD acceptors)
- Getting FP service from Puskesmas
- Age between 25 – 44 years old
- Lower social economic class
- Secondary education or less

Provider:

Nurse midwives, who serve family planning clients in Puskesmas (and have experience minimum 3 years in any Puskesmas)

Community Leader:

Formal community leaders (do not have to be a *Camat* but can be the staff of the sub-district office)

Informal leaders who have sound influence on the actions of community, including NGO, civil society, and religious leaders.

CHAPTER TWO: DESCRIPTION OF THE RESEARCH AREAS

INTRODUCTION

As mentioned in the first chapter, the study was conducted in two provinces, i.e.: West Java and Lampung.

KABUPATEN KUNINGAN

In West Java, the study was conducted in Kabupaten Kuningan. The width of Kabupaten Kuningan is 1,117 km^2, with a total population of 981,709 persons (Sensus Penduduk 2000). To the North, Kuningan Regency is adjacent to Cirebon Regency; to the South is Ciamis Regency; to the West Majalengka Regency; and to the East is Central Java Province.

The majority of population of Kuningan are Sundanese. Even though they speak Bahasa Indonesia in a formal occasion, they prefer to speak Bahasa Sunda in their daily conversation.

The capital city of Kabupaten Kuningan is Kuningan, which is lied on the Kecamatan Kuningan. Before 2001, Kabupaten Kuningan consisted of 19 districts, however as the decentralisation was applied, this Regency was developed into 29 districts.

Out of 29 districts, 3 districts were chosen as research areas, i.e. Kecamatan Ciniru, Kecamatan Kuningan, and Kecamatan Cilimus. The justification of choosing the areas of study was based on: Kuningan district represents a district which has urban characteristic, Cilimus district represents a district which has mix characteristic of rural and urban, while Ciniru district has rural characteristic. The decision in choosing of the areas was put on the local BKKBN staff as they are more knowledgeable about the areas.

KABUPATEN METRO

In Lampung, the study was conducted in Kabupaten Metro. Three villages were chosen for this study.

Desa Iring Mulyo

The Desa (village) Iring Mulyo is located in the Metro Timur sub district, in the District of Metro, Lampung. To reach the village from the provincial capital it takes about one hour by car with a distance of 60 kilometres. As public transportation, the locals use mini-vans, tricycles, and paid motorcycle jockeys.

With a population of 12.641, most of the residents of Iring Mulyo are Javanese ethnic group. They generally speak Indonesian fluently and use Indonesian as their daily language.

The village has schools, from elementary up to high school levels. They also have Posyandu. They conduct the Posyandu meeting once a month and there is no midwife living in the village. The nearest Puskesmas is located only about one kilometre or about fifteen minutes walking. This clinic has equipments for birth assistance, offers immunization for babies and mothers as well as family planning services, and has an emergency unit. It does not have rooms for patients to stay in and it does not conduct pregnancy exercise.

Desa Yosomulyo

This village has a population of 5,461, majority of which is Javanese. It is located in the Metro Pusat sub district, which means it is in the capital of the District of Metro. The distance between the village and the provincial capital of Bandar Lampung is approximately 60 kilometers or about an hour by car. The people use Indonesian as their daily language. There is only one mosque in the village and there are four elementary schools, but there is no middle or high school. The Posyandu is rather active with about eight meetings each month. There is no village midwife in that village.

The nearest Puskesmas is only one kilometre away from the village so people usually go there by walking. The clinic serves five villages, with four physicians and six midwives. One of the doctors is a dentist, with dental equipment in the Puskesmas. The clinic serves immunization for mothers and babies and offers family planning services. There is no facility for residential treatment; neither does it have an emergency unit. The clinic also does not offer birth-assistance service and does not do pregnancy exercise.

The health providers tend to complain about the lack of medication. Only generic medication is available in the clinic while the providers think that since it is a central clinic it should offer patented medication.

Desa Bandarsari

Banjarsari is located about 45 kilometers from Bandar Lampung, the capital of Lampung or less than an hour by car. It is part of the Metro Utara sub district. Just like the other two villages, most of the 8.375 residents of Banjarsari are of Javanese descendent. The daily language is Indonesian. The average income is Rp. 100,000 per month.

Although low in income level, Desa Banjarsari has four elementary schools, one middle school, and one high school. It also has 23 small and medium religious places.

The Posyandu holds about nine meetings each month. The Puskesmas is just a kilometre away so it can be reached by walking. The clinic conducts pregnancy exercise and offer immunization for babies and mothers. It houses an emergency unit. The family planning methods available include injection, IUD, and pills. Four physicians are on duty and there are three midwives. The clinic serves four villages around it.

CHAPTER THREE: RESEARCH FINDINGS

INTRODUCTION

The findings of the two provinces will be described based on the research questions.

Definition of quality FP service provision from the clients/providers/leaders perspectives

Clients

Table 1. Experience in FP service

West Java	Lampung
Various experiences in using health-care service are shared by each participant. The experiences have one thing in common that is the participants join Family Planning at the beginning of the program. As part of target society, some participants confess their lack of knowledge at that time. That explains why it is not difficult to find differences in recent health-care service approach. One participant even shared her past experience that she once put two contraceptive devices at the same time. It happened due to individual initiative without sufficient knowledge. Government mobilization to reach as highest numbers of people to join Family Planning program as possible is not in line with the effort made to give better understanding at that time. *"Once I heard that when (we were) pregnant …..there was IUD which slipped into the child's back….or slipped into the head. Maybe because of wrong explanation or misinformation or someone who does not understand"* That experience can be easily distinguished from recent experience in which the *bidan* spend times to provide consultation before the placement of contraception Information plays an important role in giving society consciousness. It is proved by findings in Ciniru. One of participants' experiences showed that individual consciousness to join family planning program increase as a result of socialization among society. Experiences from the closest people such as neighbors who manage to control baby-birth interval, their having trouble in taking care of too-many children are useful comparative sources for their lives. Being static object of a program is also another	When asked about a pleasant (quality) health care experience in family planning clients mostly responded with stories about how they obtain a new method or when they are switching method. Quite a few stories are around pregnancy and giving birth. In general, though, the clients see family planning care as something routine that does not create much impression either good or bad. *"My experience? When I first adopted family planning [FP] it was the injection method."* "At that time I was using the injection method, for two months I experienced bleeding. I consulted my husband; we thought that injection is not for me. The midwife suggested me to use implant but I did not want to, because it would hurt, they said that the thing has to be inserted in me. I don't like it so I asked for pills instead. I was on pills when I got my fourth child, so it failed. Finally I just use spiral." In the specific situations that they mentioned they recalled their worries and how the providers offer encouragement to ease their anxiety. They remember how certain providers were there when they are in need. Decision-making is not a primary dimension that leads to a positive recollection of a service. Instead, they would mention such aspects as friendliness, quickness, and availability of the providers. *"I am satisfied with the service of this Puskesmas. It suits my needs, the service is swift, and the people are friendly. In essence I am happy. I also like the medicine that they gave me."*

thing the participants experienced as contraception user from Ciniru. In the past, in order to change the contraception type being used, often patients have to ask for written permission from the person or authority in charge. In other words, this legitimacy hinder patients' will to change contraception being used. This kind of things have not changed totally yet. Field findings showed society is still having trouble to take off the contraception they are using. It happened especially to clients who are using IUD. Most participants confess that they have to partly force the *bidan* to take off the device. This condition shows that clients has not enough bargaining power to decide what they want by themselves, despite of the fact there has been several important reasons explained to the *bidan* such as bleeding or contraceptive device expiration. *"….It was 1982. I was suffered from bleeding, that's why I wanted to take it off. But the bidan said I had to get a permission from chief of the village first. She did not want to take it off if I did not have the permission."* *"…At that time I wanted to take off the IUD but the midwife refused to do it. My reason for doing that is because of non-stop bleeding. The bidan simply prescribe me some medicine and asked me to hold on. I think since then the bidan became unfriendly. When the medicine did not work, somewhat I force the bidan to take off the IUD and she finally did it grudgingly.* According to the participants, the *bidan* prefer patients to choose IUD usage. However, the patients would prefer other choices because from their own experience as well as others, IUD does not work properly. Moreover, there is a lot of information that scares the patients. In accordance to the contraception side effects, participants affirm that there is a possibility that exaggerating attitude comes from the society itself. Symptoms of illness are often related to specific contraception usage. However, nowadays participants claim that such things rarely happen. Considering the cost, most of the people in Cilimus prefer government service to private	*"I like it because it is so close to my place. So I don't have to spend any money to go there. So I always go there when I need some health care."* *"When my second child was sick, I could wake her up even though it was in the middle of the night."* *"When I got back from the hospital I had to stay home for a week. In that week she always visited me, she took care of the baby, bathed the baby and all".* *"The difference is in the public hospital, how should I say it, I got angry at that time. I was in pain, the labor took a long time, and in the middle of the night none of the nurses cared for me. I said, "I am in pain how come you just go around without taking care of me." And she said, "Mam, you are demanding too much!"*

service. However, participants are aware of the weaknesses of government service. For example, society's high aspiration to be provided with service has not met yet because of lack of public facilities. Sometimes people have to wait in line to get the service. Some others have to go home empty handed because they do not receive the service they need.	

Table 2. Quality Relationship with Midwife

West Java	Lampung
In general, participants in three sub-districts (*Kecamatan*) in Kuningan make familial relationship with their *bidan*. The kind of relationship they make is that of friends, sister-to-sister, daughter to her mother or parents. Besides close-knitted one, the relationship is also functional and supportive where patients can tell *bidan* what they feel or want to know about reproduction health care. *"We're like…like friends. Just like daughters to their mother. Maybe if [they are] parents, just like children to their parents. We're like friends, like sister …. I call her ceu Cucu, so I don't call her bidan anymore. Not Ibu bidan no. Ceu means sister so…"* It is admitted that situational factor frequently determine the quality of relationship between *bidan* and clients. The harmonic relationship between *bidan* and patients does not necessarily means no difficult situation occurs. This fact is revealed from participants in Cilimus sub-district. They assume the complicated situation can take form in the work-pressure dealt by the *bidan* in daily service or in the patients' attitude that tend to relate any symptom to the contraception used. Apart from that, there is also particular opinion found in Ciniru sub-district. Participants' opinion elucidated that relation line between *bidan* and patients may suddenly change into a vertical one. In real situation, midwives position as a more knowledgeable party creates tortuous reaction from clients, by refusing of midwives suggestions indirectly and scares to	The clients use the words "enak" (comfort) and "ramah" (friendly) in talking about the midwives. Comfort is a quality that is sought by clients in their relationship with the provider. They want to be able to share stories with the midwife and be able to share their opinions. They know that it is their body that is being treated and in a comfortable relationship the clients are more willing to take charge and less scared of something new. *"I myself prefer a midwife who is friendly and ready to help."* *"Friendly. When we ask questions, she gives answer that is easy to understand, she does not make things difficult and she is able to offer explanation."* *"If she is mean-spirited, next time we would hesitate to go back there."* *"If I am treated well I will respond well, too."* *"The friendly one, comfortable to consult with, so we can be more intimate."* *"She has to be attentive, so we feel good."* An important part of a comfortable relationship seems to be jokes and laughters. Clients seek some level of personal and intimate relationship, at least during their visit. *"My experience is when I was to adopt FP it*

express their disapproval.

Other condition that is commonly occurs in these three sub-districts is social acknowledgement given to senior bidan seen from work experience. Even though they know that examination can be done by any bidan having the same background of study and that junior bidan are capable of giving the appropriate service so far senior bidan are more widely accepted. This thing can be caused by society psychological factor that build their trust upon midwives according to their work experience.

Nearly close to their wanted ideal description, participants think several midwives in their village have met the criteria. Some midwives even mentioned as an ideal model because of their friendliness and flexibility. Midwives who can compromise and attentive to clients' problems and cheerful are popular among the patients.

"…with bidan Cucu it happened [she met the criteria]…she can compromise you see. Well if I have a problem, it can be told straightforward..[we don't feel] embarrassed or in Sundanese gede heureuy…likes to kid around. Sundanese likes to kid around. She's …the attractive one…."

Another profile is found in *Bidan* Titin. This midwife is known for her tidy and proper placement of contraceptive device although she is rather quiet. From this midwife is also discovered another quality that is having high sense of social. She is willing to reduce FP service cost for the people who cannot afford it fully.

However, the participants do not deny that because of lack of time midwives are unable to provide services expected. Limited time forces *bidan* to provide haste services and the examination done is not meticulous. The situation usually occurs because midwives have other things to do like visiting the village or *Posyandu*.

According to participants, unscrupulous examination makes them unsatisfied that they decide to come back or re-checks to satisfy themselves. It shows that participants who are

was at the midwife's place. The person is good [enak], she likes to kid around."

"My chosen method is pill that I get through the Puskesmas. I like the midwife at the Puskesmas, she is a funny person."

Another important part of the personal, partial relationship between midwife and patient is attention to each personal needs and condition. Thus, not all should be treated equally at all time, sometimes the client demands to be taken care of first if she thinks she is in different condition than the rest of the patient.

"Sometimes I asked to be assisted quickly because I cannot stand sitting too long because I am heavy so I get assisted first."

"I like it when they assess the condition of the patients. If someone needs to be cared first she has to be taken care for first."

Of course, this is also an issue that is often complained about by the providers, that everybody wants to be served first and that they cannot wait in line. But that is always a problem that modern bureaucracy has to face among people unfamiliar with the impartial, disinterested characteristics of big public organizations.

According to the clients, providers could encourage communication with the client if they are friendly (through greeting and acknowledging the clients) inside and outside the clinic situation. The clients usually define a good provider-client relationship as a personal one. The analogy given by the respondents include neighbours, parents, sisters, and relatives.

"Sometimes the midwife passes our place, if we see each other and she greets us that shows that she is friendly."

"Some of them are not used to communicate with patient outside the clinic. They don't gather with us, we meet only when we visit the

patients in Ciniru have the determination to get the proper service, and they are willing to come again to health care centre to get the service as they want. However, interesting thing revealed from their statement that have not been able to tell the midwives that they want to be check carefully although the midwives are in haste.	*clinic."* *"Sociable. For instance, by joining PKK and group prayers."* *"We could share, communicate, just like neighbors, like friends so we can be intimate. It just feels good, we are free to express our opinion."* *"Well, like our parents, so we have no fear to complain about something to her."* *"Just like a friend or older sister. Because if the relationship is like between sisters we can chat without any secret."* *"Well, like to a relative. Relatives would feel the pain if we are in pain, right?"*

Providers

Table 3. Providers encounter with clients

West Java	Lampung
* Forcible method from the old days In the old days system that ignored people/society participation, place *Bidan* as part of the government apparatus that has absolute will. In one hand, *bidan'*s effort in applying standard and proper medical procedure should give away to exaggerating policy. In the other hand, society perceives *bidan* as a main suspect that have to responsible if something wrong, that actually caused by incorrect procedure or has no relation to the kind of contraception used, arise. Depressing experience for two sides turn out to be a part of history that is both unforgettable and unwanted by participants in Kuningan. As stated by one of them: *"perhaps because the situation is not conducive. At first they wanted to (have) it but then they become stress. This is my experience when I was still working in Puskesmas. It happened in Windu Haji blok Karang Anyar … the contraceptive device was not placed in a clinic…we came to the village…we did it in one of the villagers' house.. in the village chief's house where sterilization is not possible…so we sterilized it suddenly without her husband knowing it … he was working in the paddy fields but his wife run a small business at home…so they were forced to do it…after we finished we went home, Few days after that the village chief and her husband came to me. So they threatened me…when they first came I was surrounded by the local people. So they came to my house bringing their machete but I was not scared. He said to me "Ma'am…if you are not competent enough don't be a bidan". I finally report this to sub-district head. "Sir, I ask for your responsibility. If thing like this happen I am the one who are guilty…so the (medic) are the ones to blame…maybe KIE preparation is not well enough… so we expect that PLKB has motivated the people…so we play our part"* In reality, what happened in the past turned into	The providers evaluate their encounters with clients primarily on how technically successful they are. With pride, they told us stories about convincing clients to adopt family planning, suggesting a method that suits (cocok) the client, mastering a new kind of FP methods. Thus, the dimensions of success are mostly one-way in which the providers feel that they are in control and that they are doing their technical tasks well. Authority is of primary importance to the providers although they also mentioned being loved and respected is also important. Giving more leeway for the clients to choose an FP method is understood as a requirement but it is not something that they would consider a measure of success. Although communication between provider and client is not of primary significance in their description of their job, the midwives did mention it in their discussions. It is therefore can be seen as a part of how quality is defined at the ideal level. The midwives might not practice such empathy very often but they are aware that it is something that is required by the job. *"We pay attention when the patient shares her complaints with us. After that we have to explain the contraception and recommend the best for her."* *"They are human, they have feelings we need to attend to. We should examine them in the room with the door closed and nobody else is around so that they can talk to us one-on-one."* *"Yes, after all this is about relations between two human beings, both sides should be ready to give and take. We cannot force our way against the patient's will. We should get along well."* *"First, we have to ask them, communication is important. For example, a patient comes in for*

unforgettable memory for some people, so it is very often clients put the responsible for the *bidan* and take one step back from the decision that should be made by them. The society attitude to find 'a scape goat' is still occurs up until now and for some participants in Cilimus it becomes their exercise to choose specific approach.

"…the local authority wants me to join the FP program, they want me to place the device but if something wrong happen they don't want to take responsibility. Bidan doesn't want to take the responsibility. What upset me is the fact that it is very hard to explain. She is very emotional even though she's been using IUD for years…"

"She upsets us. That's the way it is now. They are independent now, but when it comes to fee they avoid it. In the past they are told to do it by village chief, right? So now we have to deal with this. That's what upset us. We often wonder why we have to deal with these types of clients ..we just have to be patient.."

Experience in providing FP programs service in the earlier times is a good teacher for the majority of *bidan* working in Kuningan. Various stories exposed turn out to be valuable findings since it reveals *bidan*'s position at that time and the role they could play nowadays. It has become an open secret for everyone if the introducing of a program should also be followed by pressure from the authority. This also happens in the beginning of the FP program application in the eighties until the beginning of nineties that absorbed energy from bureaucracy apparatus, such as the local highest authority to the army, supports the application of the program. Although some of the experiences remain as trauma for participants in Kuningan there is unspoken understanding that such method has to be carried out to involve the society in the beginning of the FP program as affirmed by the following statement:

"…when I first (went on) duty in Ciniru sub-district…dealing with the FP acceptor…it was 1982 so a lot of people do not have any idea about the program that they have to be forced in some extent to join. Even the army escorted family planning, we would ask her what kind of method she wants, but if there is a financial problem, we could ask what the occupation of her husband, perhaps we can help her with an effective method that she can afford. So they key is communication."

"In parent-child relationship, the parent can be angry at the child but midwives cannot do that. No matter how defiant the patient is we cannot get angry with her. We just have accepted it or just grumble behind her. f we look angry in front of her she would not trust us anymore and she would spread the words that midwife A is rude. Our reputation would be smeared."

us to come into the villages… to mountainous area and we had to stay overnight since there were no transportation at that time… but thank goodness they wanted to join the program though they probably did it because they were afraid of the army." *"…but in the 1984 up to the nineties we used system arranged by the government to find the PF acceptor. It was a target system so we have to reach the target planned no matter what it takes. KIE did everything they could to get the acceptor candidate regardless the way to get it. The regent instructed his apparatus to be FP acceptor that he even used special moment, for example, Army Day, Mother's Day. They used such method because the regent wanted Kuningan to be IUD regency…back then the chief of BKKBN was doctor Kopeng ..well. he wanted to make this regency as IUD regency so they force the people to do it."* A tremendous changing from the earlier times to the recent times is the biggest challenge the *bidan* should take. Aside from the shifting of political and social aspect, economy creates new problem. After the monetary crisis the government does not give full subsidy as it used to. Contraception is no longer free of charge at all times. Consequently, the fee is charged to the FP acceptor. The reduction of subsidy done in nearly all kinds of contraception, especially implant, which resulted in limited PF service in *Puskesmas* merely for contraception provision. Services available at all times are simply IUD placement and injection method. Meanwhile in the grass root level not many clients tolerate such thing. A lot of clients demand the FP service as health care facility that can be utilized freely. As it is stated by participants in Cilimus and Kuningan: *"…once they sensed something wrong they will complain and annoy us… back then money is needed to set up the contraception …although they benefit from that…They are independent now, but when it comes to fee they avoid it. In the past they are told to do it by village head, right? So now we have to deal with this. That's what upset us. We often wonder why we have to deal with these types of client. ..We just have to be patient. No matter how angry we are we*	

don't show it to the patients.. We uphold our good image.."(a participant in Cilimus). *"In the past FP was still enjoyable, right? They persuaded us to come, they took us there, and it was free of charge, now that's what people wanted. But now it seems like that we need it, we are the one who want it badly. It used to be free of charge but now people have to pay it themselves, be independent…" (participant in Cilimus).* *"Well, since the crisis government does not provide subsidy anymore, so they deducted the subsidy… well maybe we are expected to be independent" (participant in Kuningan).* * Contraception malfunction and side effects Experience Various experiences are shared by participants in three sub-districts. Due to unique characteristics in each area, dissimilar stories are conveyed by participants. Nonetheless, there is a common pattern occurs in those three sub-districts, that, is clients' tendency to relate malfunction of contraception or symptoms of illness with side effects of contraception. Such things especially occur in Cilimus and Ciniru sub-districts. As it is shown through the following quotation: *"So before they use the contraception people has already known about the side effects. When you use IUD you will feel this and that. Most people only heard about the bad side. They heard about the failures or that something wrong happened. So they probably heard only few percents of the good side. It is the malfunction that is kept in mind…" (participant in Cilimus)* *"…for example, if someone feels ache in her nose, she will connect it right away to the IUD, so sometimes we feels nausea. She said IUD is like ear-rings, so if she feels sick it is caused by the nearest ear-rings so the she wants to take off the IUD she has to take off the ear rings and also the necklace …most people here are like that…" (participant in Ciniru)* Meanwhile, participants in Kuningan admitted the changing of society attitude recently. They said:	

"Thank goodness it has no side effect now…it's very seldom…to find side effect like bleeding for example…back then when people were suffered from ear-sore they thought it's because of the IUD, eye-sore …it must be IUD, they knocked our door at one o'clock in the morning and ask us to come to the village…imagine that…" Attitude development also includes ways to avoid as their protest against or disapproval of the approach made. Like stated by a participant in Cilimus. *"They only stay away if they don't like it. If they were informed they didn't say anything. In the old days they would bring machete or something…"* A mistake in placing contraception is very likely to happen. However, for participants in Kuningan the problem lies in how well clients are able to anticipate that. At least a better understanding from the beginning should be given. *"…When it comes to malfunction well I don't know how many percent. I am a bidan yet I experienced malfunction of the contraception that result in my second child. Since I have experienced the malfunction myself I use my own experience to explain it to patients. Contraception is made by human so it is not flawless. Failure or malfunction must happen to some extent. Maybe ten to twelve percents. Take me, as an example. I know the chance of malfunction because I experienced it myself. I've been using IUD for two years. Then there was malfunction that's how I got my second child. So for me it's easier to explain because it's my personal experience. I was suffered from bleeding when I was using IUD. But IUD fits me well. Now I am using IUD. Other contraception does not work well…"* Aside from the shifting old system, various experiences turn out to be diversity found in each sub-district. Experience shared by participant in Ciniru is one of the diversity. Although they don't have much experience the *bidan* serving in those three sub-districts is expected to be able to handle every obstacle come up, either obstacles caused by poor	

physical facility or those caused by cultural-social aspect just like what they revealed through the statement: *" … we often go on foot (laugh) when we perform the duties we often softly complain the devoid of transportation. It is recently that Mt. Melik's roads have not been asphalted yet. It took us two or three hours walk on foot to get to the village. I guess it's about nine kilometers…."* *"…When I first arrived here, since I came from Bandung not Kuningan, I had trouble with the language used. In here, "mules" means sick while for us "mules" means pain in the stomach. When I asked," How do you feel, Sir?" He answered, "I feel mules", so I thought the pain was in the stomach but it's not…."* Different characters of clients need different approach from the *bidan*. Some *bidan* in Ciniru often have to deal with 'pig-headed' clients who refuse their considered opinion. The best approach to cope with this problem is not an easy approach, for *bidans* will find themselves caught between the expectation to run the medical standard procedure and the expectation to consider client's decision to his own choice. *" …a fault that leads into a problem in other sectors somewhat occurs. Rumours spread fast…for instance there was this acceptor candidate who chose injection. Although her blood pressure was pretty high she insisted. I had advised her, other bidans had explained about the possible risk come up but she still insisted to get the injection. Perhaps that's kind of thing that needs patience to explain. We had to hold on our principles, right? No injection if the blood pressure is high. Like one hundred and fifty or one hundred and sixty. But she still insisted. If it happens we prescribe them medicine to lower the blood pressure then ask them to come back in three days. If the blood pressure is still high we offer them to choose IUD, but they still insist then we prescribe them medicine again and again until the blood pressure is normal then we give them an injection…"*	

The changing atmosphere of political and social aspect has make ways to the changing of social behavior as well as public service. That is felt by participants in three sub-districts. Health- care service put clients' need in the top of the list; meanwhile *bidan* will give further motivation and explanation needed by clients. At least, the recognition that quality is more important than the number of the FP acceptor is represented by one of the senior participant in FP program service provision. *"…there's not much difference from today and the earlier times. Back then they are very concerned with target but now they pursue quality. So we don't really care if they want to have another child or not…they are should be the ones who need us …if they are ready they would come to Puskesmas. We will motivate KIE that consult us so it's two ways direction…so since they need us they come to us… although some people still have to be persuaded or ordered to …finally we motivate them, explain them…this is IUD, injection or pills… we don't want to force you, so please choose which one you need…"*	

Table 4. Midwife-Client Relationship

West Java	Lampung
Most *bidan* who participate agree that the relationship between *bidan* and clients is quite close. It is like the friendship or familial relationship. Familial relationship can be seen from the behaviour shown by clients whenever the *bidan* visit them. They address the *bidan* as *teteh* or *ceu-ceu* (sister) or *mami* (mother) that displays harmony between them as it is stated by *bidan* participating in Kuningan: *"so now we are quite close with the patients or our clients. Some call us Ce-ce or Teteh…some other calls us Mami. Since we are pretty close with them once they came here…to Puskesmas and they didn't pay…but along with the retribution because there has been (perda) which states the tariff for the placing and the opening of the implant they are willing to pay but because we are close to*	A good relationship with clients is usually defined as friendship and as fellow community, or even family, members. Although they do not expect to have intimate relationship with all patients they are happy to have one or two patients thankful for their services. *"Perhaps like relatives. For example, if she has complaints and she considers us a relative she would just express them all to us. As a health provider we would acknowledge her complaints and probably suggest something."* *"We need each other. It is very different from the parent-child relationship. I would say that the relationship is uniquely a patient-midwife relationship."*

clients we tell them they could come to our house to pay the fee later…" In reality, they often come to *bidan* to discuss about their personal problems. That includes a very personal topic such as their sexual intercourse with their husband. Field findings showed than they did not only come to the experienced or senior *bidan* but also come to the younger *bidan* ones just like what happen in Ciniru: "They even complained about their sexual intercourse with their husband. They said," I use IUD, but my husband said it's pricking every time we have sex. What should I do?". So we check and fix it. They are very open if there is something wrong…".	*"The patient treats me like a relative. She still visited me sometimes. Last Lebaran she still came to my place."* *"Ya, for example a thank you from the patient because she could resolve her problem. Usually they are unsure with the choices in family planning and after they have a counseling session with us and choose a method they can come back to us to thank us. Thanking us because we helped them find a suitable method. I am happy because it indicates that the patient understands what we explain to them and that the patient follows our advice."* *"Sometimes they insist on giving us gifts. That surprised me because it is our duty to provide clear information [about family planning]. Sometimes because they think the information is good they gave gifts. For instance, I once was given a holiday gift, money for the Lebaran day. I truly experience this. Up to now, the patient still visits this clinic."* Some midwives also see their involvement in the community functions as something that is required to maintain and improve their relationship with clients and the community as a whole. *"Because we are a community we don't have to meet at the clinic. We can see each other at the market. This is such a small community. They know who I am; I could still remember them and their problems. This is only a small village."* *"If there is a gathering or prayer in the surrounding area naturally we would know. If there were a baby ceremony we would attend the event. We have to be sociable."*

Table 5. Adherence to procedure

West Java	Lampung
The general procedures conducted by midwives are: providing information when clients are	In terms of procedures, most respondents do not see it as an issue. Knowledge of procedure

pregnant and when they are giving birth to join FP program 40 days after the delivery, providing counseling on the side effects of each FP method. Then, if clients want to have IUD to be inserted, they first check the mothers' womb/uterus in order to make sure whether the device suit or not to the clients.

The standard procedure they apply to every client is as follow:

"first we check their blood pressure, weigh them, then check their breasts whether there is something wrong in them, and we also ask them what they want."

"…we prefer to provide service to those who just giving birth-40 days after, as the vagina is still soft and make us easy to insert the device. …"

The majority of participants mentioned that sterilization is different from other FP devices. It needs special treatment, and so they cannot do it. However, they only can provide counseling and refer the clients to the hospital.

"…if sterilization, we only give counseling, and we ask them to register, then tell the clients if they want to do that so and so will happen …"

In addition to providing a counseling, *bidan* should also ask an informed consent from the client's husband..

"*we have their paper with their husband's signature. Therefore, counseling is a must. If the husband complain what we can do …?"*

"sometimes the husband is away from home. We are afraid if they come to us and complain. That is a hinder to us and that is one reason why we ask for the husband's informed consent …"

Some bidan utter that they used to show the picture of the uterus (they draw it by themselves) to the clients. Then they will check their urine. When they want to do an instalment, they will show it first to the client, so they know what it looks like. After that, they will ask the client to come again one week after. Some bidan mentioned that only those who have certificate could do the instalment of

is considered a part of the definition of their expertise. However, the research only investigated their feelings and perceptions of the procedures or how the midwives think they have been following the procedures.

"We prepare the equipments. I use formalin to sterilize the equipment. I tell the patient to wash her hands with soap. When this is done I ask her to get on the bench. After a full examination and everything is okay, I wash my hand and put on the gloves. I always told them to come back if something is swollen or if there is a bleeding."

"For instance, IUD, it is difficult to motivate patients to use IUD. Because they are worried that it is big. We have to show them that the part that will be inserted is only this big and they don't have to be scared that there will be side effects. "

"Usually we don't have to do much talking anymore because the patients are firmed with their choice, the family planning field agent has explained it to them, how it will be inserted, what would be the effects. They know it all."

"Her age is about 25, her child is three years old. She chose the three-year implant so that by the time her child is six she could get pregnant again. So she's very sure about her plan and her spacing. When she first came we check her blood pressure, we weigh her, and complete her paperwork. Inside we only have to insert the implant, everything is taken care of outside by other people. We are, you can say, sterilized inside. Others even prepare the tools for us. We just grab the sterilized container and take the implant set. We showed her the implant, this is what we are going to insert into her arm. But they knew already about the one with six capsules, most of them knew it. This one is similar to Norplant but it is a little bit longer and it has two capsules. They have made up their mind when they get here so there is no stress at all, just business as usual. There were a few moved from pills so while inserting we explained the implants to

IUD and implant, or those who are under supervised by senior midwife.	*them. "See they are just small, right?" It was not like they have heard before that we have to make a big cut. For most of them after they see the implants they become more relaxed."*

Community Leaders

Table 6. Leaders-Providers Relationship

West Java	Lampung
In general, the majority of community leaders (ToMa) who are males have never experienced direct contact with *bidan* in *Puskesmas*. What they shared in the discussion are their wives' or their relatives' experience. One of the community leaders (ToMa) narrated the group about his sister who had good facilities, good treatment using simple equipments. The *bidan* was patient and she had nothing to complain up until now. The discussion revealed that some *bidan* are unfriendly and patients have to queue for such a long time that some of them have to use private *bidan* service. However, in general community leaders admitted that *Puskesmas* was very helpful for patients who are not well to do and they hoped the service could be highly developed. According to some participants, service provided by *Puskesmas* was quite excellent since the *bidan* are brisk and attentive when it comes to problems faced by the clients. Other people in *Puskesmas* act the same way as the *bidan* do. If a client has a problem, for example, then she can notify her problem to a cadre before she informs it to *Puskesmas*. **(Ibu2 PKK**) and FP program' officers do not feel reluctant in taking clients to *Puskesmas* or when it is necessary, to a hospital. *"…so I think the FP program service provision is good enough…because the officers here are pretty attentive and helpful. There are often complaints in [the process] of FP program …but the community is expected to call us as soon as they have complaints… in fact, if they have complaints the officers take them here/… for example, why it is better to put them into hospitals, in here they are taken (to the place*	In reality, community leaders—both formal and informal—have been working hand in hand with health providers for quite some time. They, therefore, readily offer descriptions about their current relationship with the midwives as well as their expectations of the relationship. Some, usually in the government, even have regular meetings with the midwives. This could be a basis for further community-based efforts even though some restructuring to place all parties equally and put community as a subject needs to be done. *"As an NGO activist I see health providers or midwives as partners. I think they are very helpful as partners in empowering the community. We do our programs together and it is beneficial to both sides."* *"My relations with the midwives are formal because we meet usually during official meetings."* *"When the midwife was about to go Haj, many people came to her place and to take her to the airport, almost everybody came to help. This indicates that she is a good person. "* *"As a religious leader I expect the providers to be our relatives so we are close to each other. That way harmony can be established."* *"Relations like between best friends. So we sometimes greet them like "How is it today, Mam, do you have a lot of patients?" So, besides official relationship I expect to have friendship and familial relations with them … Well, in reality there are some officials who*

needed)… and they are picked up from a village by (ibu2 PKK) From a personal interview, one of the community leaders revealed that community encouragement in searching for health-care service is by holding on principals of match and trust to their medical officers. *"…beside [the bidan is] experienced, when I go there it (the medicine) works well and I almost always feel satisfied, so I always go there. Take for example, those people who live there who had undergone a vasectomy, they still come to them (the bidan) no matter how far the distance is…maybe they have already known that it is effective…so [they] learned form their experiences…sometimes when they go to others who are more skilful/knowledgeable it does not work, perhaps because they [the bidan] are not accurate."* In terms of *Puskesmas* service provision, basically people choose a *Puskesmas* due to its location and the cost charged. According to some participants, community leaders and *bidan* both feel that they need each other and the relationship made is that of familial relationship. The reason is because both sides serve their integral functions, that is, *bidan* as a party who provides medical health-care service physically and ToMa who provides service needed spiritually. *"First, these two parties play their own roles; bidan's function is to serve physical health-care provision…and community leaders' function is to serve spiritual provision and to raise one's spirit back and will to prepare one's life after life . So they complement each other…they are not overlapped instead they work in cooperation to serve one purpose: creating one community who is healthy physically and spiritually… healthy physically [facilitated] by the bidan, the doctor along with their apparatus…healthy spiritually [facilitated] by these community leaders…in creating healthy Kuningan 2005."*	*ignore the midwives, those are the leaders with the high social status they act as if they do not care so they don't make friends with the midwives."*

Smart decision-making is part of the quality definition

Clients

Table 7. Ideal Midwife

West Java	Lampung
Nearly all participants have similar opinion about an ideal midwife. Personal characteristics sought at first are friendliness, the ability to tell clients persuasively, and the ability to follow up problems undergone by clients. Other characteristics such as kind, patient, are able to do meticulous examination are also mentioned by clients. Aside from that clients also expect *bidan* to inquire questions and give explanation to patients. Nonetheless, after soliciting deeper about actual profile from *bidan* surround them, the quality of *bidan* does not only concern their personality but also take in skillful quality and scrupulous aspect in contraceptive device placement. *"..[those] who can place [contraceptive device] properly… [those] who are friendly/ sociable/ terrific services… Bidan Titin and Bidan Cucu put together."* *"We like bidan who is very good at placing contraceptive device so that we feel comfortable and safe when we are checked or examined."* Focus group in Cilimus mentioned that "popular" midwives there are *bidan* Susana, Yeti and Iin because they pay patients who have just delivered a baby a visit everyday, and they can handle patients who have trouble in giving birth themselves. Those two characteristics added up an ideal or actual description of *bidan* profile. Beside that, *bidan* is expected to provide equal service between the haves and the have-nots. According to the participants, it would be better [for them] if placement of contraceptive device were free of charge. Participants also stated that *bidan* should have feelings, meaning that they can give understanding to the patients who are not wealthy enough to pay the family planning service cost in credit.	Accordingly, and ideal Bidan is a friendly one, a skilful and quick one, one who is ready to offer advice, one who offers to be a company, someone who does not seem to stress too much on financial gain, not temperamental, available, and in general understands the psychological condition of the client. Above all, they like midwives who they think have gone beyond the call of duties and treat them humanely. *"What I like is when we need help we can say please help us now, we don't have any money, and she would say it is okay, what is important is that you get the medication now."* *"The last time I gave birth was in the midwife's place. Her house is not far from here. She treated me, provided food, medicine, injection, and all. She cared for me one full day. When I was in labor she was always with me. She waited on me until the baby was born. I gave birth on Monday, on Tuesday I was sterilized and everything went okay."* *"She once gave me extra milk for my baby. It was her own, it was not from Posyandu although the Posyandu also distribute milk."* *"I wanted to walk over there but it is quite far and there is no transportation. Well, I don't have any money to use the transportation. So the midwife told me to come to her place after work. After that she even took me home."* *"When I gave birth she even gave me some money. You know, I have nothing. When the midwife gave me money I was so touched. I did not know what to think. Up to now we have a good relationship."* *"The good thing about going to her is even*

Beyond that, refer to a participant from Ciniru sub-district, a midwife should be experienced. They do not like the fact that a midwife in *puskesmas* asks a local village midwife to serve them. Participants think that midwives from local village are not experienced enough so they are afraid that there will be something wrong in the placement of contraception. For all the ideal midwives characteristics above, participants from Ciniru suggested to use the term "Bidan Teladan/Midwives Role Model"	*though we do not have the money we can still seek health care there. When we get the money we can always pay her."* *"She understands poor people. My own experience is when I gave birth I could just leave although I did not have the money to pay her at that time. With other midwives we would have to pay first before we can leave."* In contrast to the providers' perception, clients do not emphasize on technical authority and skills. Friendliness (ramah) is almost a key term for most respondents. However, a provider reputation is also built on stories of how they gave out good medication and that they are dependable and reliable. *"She has to be quick in making a decision. For instance, if she is no longer able to assist the patient she has to quickly take her to the hospital."* *"In essence, I mean, she has to be thorough and friendly, too."* *"I like it when I get attended quickly, the treatment is good, and she could offer good advice."* *"The midwife is a quiet-type. She is not rude and many patients gave birth over there."* *"Well, maybe for sharing it is good with a friendly [ramah] midwife, but to get medication or to insert an FP kit I prefer to do it with a skilful midwife."*

Table 8. A Good Client

West Java	Lampung
Opinion about good clients or patients is shared variously in three research sites. In general, participants in three sub-districts think that good patients are those who have courage to ask questions or speak out their problems. In other words, the success of the program is related to their open attitude. An opinion from participant in Cilimus serves as a good explanation: *"The patient should be open, so if she wants to be explained or she wants to know how to use it if or when she was sick, so the midwife is also…"* *"If she is sick she should tell the midwives what is she suffered from so when it is time to check the midwife has already known the sickness, what does she feel, things like that. So for the midwives, this kind of patients they are expecting, who are open about their complaints, so don't go to that midwife, if you are sick go to other midwives … some people are like that. Maybe we have to be patient in waiting for our turn, now maybe the midwives would like that kind of patients."* Openness does not only concerns with finding information but also respond positively to the contraception that has been placed, voluntarily. *"Tell [the midwives], … tell them if the contraception that they have placed fit us."* More specifically, participants in *Kecamatan* Ciniru describe a good patients are that who knows a lot of information about family planning and has chosen the type of contraception they are going to use. *"it means that if we go to health care centre we know what to do, we already have purpose. Have you known what to do, what to choose, IUD or injection…"* For participants in Kuningan, acquiring information by asking questions benefit the clients, that is clients can tell what their body feel spontaneously and receive proper care	As long as there is no obvious problem with a certain midwife the clients tend define a good client by the extent to which a client creates a fruitful health care situation. To most, it is a responsibility to stand patiently in line waiting to be cared, being disciplined when in the clinic and, of course, complying with the medical advice given by the providers. *"We have to be patient because wait for our turn when we need something like medication."* *"Because the midwife knows better than we do."* *"Well, a good patient is one that does not complain a lot, I think."* "A good patient is one that obeys her midwife. If she asks us to take the medicine we have to do it. If we don't how we would heal. Sometimes there are patients who refuse to take the medicine prescribed the midwives."

needed immediately. Moreover, openness will benefit, women especially, in facing obstacles in having sexual intercourse with their husband. *"It's for our own good. If something happen we are the ones in trouble. So we have to know the side effect. So just be open, neng, if possible knows everything so you would not feel regretful in the end. If I have a problem I ask ..once I get the thread…when it is first placed "be careful neng", he said when it's the first time…. "* Other than that additional characteristic is still needed. Although one cannot say that midwives is in higher position that makes them superior to the patients. Nonetheless, patients should posses that characteristic. The following is quotation from participants in Ciniru. *"Follow their advices….be patient…when you have to wait in line…be patient.."* Some participants added that to be an active client they have to have money so they will get service from midwives. This statement is interesting because there is economic factor in defining the quality of health care service. Unfortunately, this matter does not catch the facilitator's attention that they did not conduct the deeper research concerning this matter. In reality, participants admit that they are not active clients because only few people among them that asked questions when receiving health- care service. They admit that they often just sit still and wait until the midwives asked them. A participant who is an injection acceptor claims: *" … the side effect from injection is irregular period and dizziness. But I don't dare to ask the midwife, I just hold on the pain.."* It happened due to her lack of knowledge of contraception side effects and also the reluctance to ask the midwives. The term they agree on for clients having characteristics mentioned above is "Active client or clever client"; some call it "good	

patient" or "model patient". The participant is not familiar with the term bright or smart because it refers to clever children, quick at learning, dare to ask questions and feel what they want to say if they have complain or problem, strong will, meticulous, perseverance, diligent, can be a good model for others and are able to express their opinion.	

Table 9. Obstacles to be a good client

West Java	Lampung
Openness atmosphere which benefit people living in village often has not spread equally yet. This belief is proposed by participants in Kuningan that thinks the reason why people are not active during the health care service is caused by lack of information and socialization *"..there is a lot of burden at home…lack of socialization, makes him not clever enough/ socialization helps you improve your knowledge, broaden your horizon…"* Different from the above point of view, participants in Cilimus judge that there is a combination from several reasons that weaken client's motivation to be active. Those factors are seen from three points of view; the midwives, the clients themselves and situational factor. In the end other people's comfort will be taken into account which control the decision to be active as it is shown in the following quotation: *"… the midwife was busy…when she was busy it was difficult to ask questions. Some midwives said "later. later I have patient to take care of…later if the new patients has been taken care of…when we want to say something…it's like she is busy doing something so we wait but at the end "later…" she said so we feel embarrassed to ask about that again.."*	According to the clients, there are some obstacles to become an ideal client, which include: the economic situation of the clients, the relationship between provider and client, the limited time that providers usually have, and the psychological barriers between providers and clients. *"A friend of mine is afraid of the midwives, so most of the time she just asks her friends."* *"I like the friendly midwife, because if the midwife is skillful but not friendly we will be scared. We are afraid that she wouldn't know us and she will become unfriendly."* *"Well, their time is limited, you know."* *"If she is not too busy…"* *"When she answers us in a hostile way. So we hesitate to ask further questions. But if the midwife is good and friendly when we ask questions, we can chat, we can tell jokes together. So we are not scared to ask questions.*

Table 10. Situations of being an Active Client

West Java	Lampung
The courage to ask questions and express what they feel will benefit the client that is client can explain what her body feels spontaneously and receive proper care needed immediately. As in the following quotation: *"but if …only if he needs us, it 's impossible to say we are not there, we have to say something to him, if we have something to complain it's our lost not them…"* For most participants, acquiring information by asking questions benefit the clients, especially for women facing obstacles in having sexual intercourse with their husband. *"It's for our own good. If something happens we are the ones in trouble. So we have to know the side effect. So just be open, neng, if possible knows everything so you would not feel regretful in the end. If I have a problem I ask . .once I get the thread…when it is first placed "be careful neng", he said when it's the first time…. "* Participants also affirm that if they are active they are more knowledgeable and are able to handle things in houses so they do not get nervous. In other words, when they know the side effect resulting from the usage of contraception, they can handle it, especially for small things that are not dangerous.	A client would be more active when they have a good relationship with the Bidan and when the client think that there is something really important, such as in emergency situation, when rumours need to be clarified, or when they are feeling a certain symptom. Included in such special situations that encourage clients to be more active is when they switch method. In other words, most clients would ask questions only when they need to. *"For instance, about diet. If we are unsure whether eating something would cause complication we should consult the midwife. We should ask her whether we could it this or that if we are in a certain condition."* *"In my opinion, we have to ask questions. If we have a certain complaint, we should check with the midwife what it is and what should we avoid. If we don't ask we remain in the dark. And if we don't know what our condition is we could for example eat something that we should not eat so our sickness would not heal quickly."*

Table 11. Decision-making in Family Planning

West Java	Lampung
The recognition of long-term advantages from FP as a program to control birth has become widely- spread consciousness among society. This fact shows the shifting of old traditional system to a more modern one. The idea about a small and planned family has internalized into logical consideration that breaks down myths believed by the society so the new value and system now has been established. *"…no, a lot of children can give us trouble. So*	Apparently, to these respondents, cost of components and service is of primary importance. In making decision about the choice of methods the midwife plays a significant role. However, the clients often indicate that ultimately they are the one who makes the decision, often with influence from their husband. Midwives can only offer explanation, advise towards one direction or another but the clients will decide based on

you have counted your salary, for example if I earn this much … how much will I have to give to each of my children. that's trouble. Not to mention about their education, health care… we thought about it. In our village the leader and the respected elders also give us such understanding… so a lot of children does not mean a lot of fortune but a lot of troubles, …"

In other words, participants' decision to join FP is in relation to the growing of new system in society that controlling birth means providing guaranty to their future. For participants society consciousness has turned into the decision-making and individual action. The next statements were quoted from participants in Kuningan:

it seems like people need Family Planning, to know the difference or interval period between children, they do not want to take care of children like they did in old days.."

"I don't understand how my mom managed her children but nowadays she thinks the mothers are more clever. Knowledgeable…so they don't need to be forced. They will try to find out themselves…"

"…Old people used to say: a lot of children means a lot of fortune. It's a lot of fortune all right, but it's tiring, children need education. The eldest have to go to the university while the youngest still needs to go to school. so they could only afford their children education not far from Senior High…"

Following the dynamic of society, family as its unit, begins to place FP as part of its priority scale. Straightforwardly, data concerning this matter is found in Cilimus that represent family priority from housewives point of view.

"…number two. Number one is economy that is needed so number two is FP. FP is considered as number two in terms of need. If the family's economy is not to well, then they don't join FP so they will have a lot of children what would happen to them after that? Their economy is not to well."

Decision made by participants is related to the society collective consciousness that controlling birth will guarantee their future. As whatever information she believes in and on the cost she can afford. So the issue is more with the quality of their information and selection made available to them rather than with the ultimate decision-making.

"She offers to insert spiral, but I was afraid, so I refuse."

"She asked me to switch to spiral but I am the one who did not want it. I asked for pills, that's what I want."

"As for me, it was my own will, I want to be sterilized. I don't want to have any more child."

"I was the one who asked [for a specific method]. After my first pregnancy I used injection until three years. After that I switched to pills. I cannot use the other methods. Now, I want to try spiral."

"So I asked the midwife. She said I could either use the once-in-three-months injection or the once a month injection. I chose the three months because it costs less and I also wanted to try it."

"After my third child I was told to do sterilization but I don't want to, I want to use IUD. The midwife suggested sterilization but I found IUD to be better for me even though I get a lot of menstruation. But [the midwife] did not force me to choose one thing over another."

"Well, that was recommended by my husband and I was also afraid of using the spiral."

for participants society consciousness has internalised into real action and decision made by the local housewives. *"I don't understand how my mom managed her children but nowadays she thinks the mothers are more clever. .Knowledgeable…so they don't need to be forced. They will try to find out themselves…"* Almost all participants admitted their husbands' support in decision making to join the FP. Supportive attitude is also shown by their parents. In general, participants claim that their husband support them because they are aware of economical burden that has to be bear when they have many children. Such attitude is explained by a wife in a more extreme manners by one of participant who are "rejected' by her spouse in having the sexual intercourse because there is no guarantee from her wife's contraception. Apart from the similar experience with contraceptive device, husbands' role-plays important role in choosing and changing the contraception used. Often, the changing of contraception is done to be able to 'satisfy' husbands. It is proved in the following quotation: *"…it is used all the time right, it's easy, he said 'it doesn't feel good', no it feels okay, he doesn't know that it is being used.."*	

Table 12. Channels of FP discourse

West Java	Lampung
Most of the participants claim themselves as active individuals in terms of FP service. Formal and regular forums such as *Posyandu* and *PLKB* consultation serve function as a place to talk about FP service. In fact, participants use PLKB service as preliminary consultation. The majority of participants also try to broaden society acceptance of FP through daily conversation with their closest community (husband, parents, neighbors) or other informal meeting like *arisan* - regular social gathering - whose members contribute to	Although community prayer groups (pengajian) are prevalent the clients do not think that such a channel should be used for family planning communication. *Q: At the prayer groups, do you talk about family planning?* *A: No, we just chat about our daily life.* *Q: Do you often talk about [FP] in the prayer*

a take turns at winning an aggregate sum of money. *"….to friends, I guess. I guess people who have benefit from FP…like me will inform this to other people. We persuade them to join the program. I took most of my friends to bidan…'using injection is better like this one…' That's my experience.."*	*group?* *A: No, just once in a while.* *"In the prayer group we never talk about FP. Anyway, only the elderly go to the prayer."* The clients usually talk about family planning issues with their neighbours and the events that are primarily used for this purpose is the PKK and Posyandu gatherings. They exchange information among them and sometimes become a consultant to each other. Family planning cadres are the contacts they often talk to about family planning. In the community gatherings the clients expect that providers would be involved as a member of the community. *"I told my friend to use IUD but it turned out that it does not suit her well so she switched to pills. For months she experienced dizziness. I asked her how she was doing. She said she was worried because there is plenty of blood during her menstruation. I told her to just go ahead, she would get used to it."* *"With neighbors we talk about FP during our mother club meetings [arisan] or at the market. We do not have PKK activity here. During Posyandu we often talk, too. We ask each other questions."* *"Sometimes I talk with the neighbours, or with my husband. Usually we talk about our experience using FP methods because, you know, there are various methods used. Sometimes there is mother who wants to switch methods so we talk about those methods. We also talk to those who have not joined FP."*

Providers

Table 13. Good Clients according to Midwives

West Java	Lampung
The most important quality that makes a good client is one who has informed her about basic	Actually, the providers tend to remember better the clients who are not complying with their

knowledge. Basic knowledge does not only mean the kinds of contraception available and its usage method but also the advantage and disadvantage of the contraception used including its side effect. In addition, clients' active attitude has already firm before they see the *bidan* in *Puskesmas*. An active process is obtained through varied facilities and media like tutorials or printed media. It is shown through the following statements from participants in Ciniru and Cilimus:

"…to me an acceptor means someone who has already acquainted with kinds of contraception and maybe its side effects, listen to tutorial, read newspapers or anything can broaden our view, can make us clever…" (participant in Ciniru)

"…we expect the patients to know by themselves, that they have to join this kind of acceptor. They come because they want it and let us know their choice and ask whether it will work well or not. So that we know what to explain in consultation session. They are also expected to know the side effects of the contraception chosen so if symptoms which have nothing to do with the side effects will not be related to the placement of contraception. It would be good if the husbands were involved in the decision-making. That's what we want…" (a participant in Cilimus)

Based on further survey conducted to participants in Ciniru, the proper term to describe active clients or patients is "a role model of patient" or "**pasien bijak**" (a wise patient). Besides that, participants also suggested the term "an ideal patient" for the reason that an ideal patient is one that is able to determine what is best for her.

"…then she ask us," If I want to use IUD, for instance, what are the side effects?" she has already known because she has asked then all we need to do is guiding and directing her [of the usage of contraception]. Since she has already known the outline she only asked for questions that make her doubt or confuse…"

In addition to the characteristics, family support also make a good client as affirmed by participants in Cilimus. Family support is advice. In fact, it is so much easier for the midwives to say the undesirable characteristics of a client than the desirable ones. Compliance is, thus, an important dimension of their definition of a good client. Not being honest about their condition (such as when the last intercourse was made, or whether or not they are pregnant) is despised most by the providers. They also mentioned desired characteristics such as "disciplined" and "obedient". However, in their definition of a good client they also include a few dimensions of "smart client" such as being able to tell the conditions she is in, having sufficient knowledge about their chosen FP method.

"In terms of acceptors, I like it when they can easily be given directions."

"It would be good if the patient is respectful. For example, the counter closes at 11, she comes at 11:30. Perhaps we can call her not a good patient, not so disciplined. You know our office hour is until 11. Sometimes they come and ask, "How come you are already closed?" "How come you close so early? It is not even 12 now?"… Well, how are we going to take care of the administrative works if we close at 12? … This is what we often face. Actually, the patient should be more respectful, friendly …"

"That is what I meant, they have to stick to the rules and they have to follow what we say."

"I prefer the active patients who can decide for themselves because that means they are firmed in their decision."

"What is important is they understand, understand the effects, understand the methods, and understand the condition of their body."

"Basically, the patient can ask us questions. Also she has to follow what we suggest them to do. If she asks, we certainly would provide explanation. So there could be communication. We need each other, right? So they have to listen to what we say and hopefully they will get well. It would be difficult if they rely on medication alone."

important knowing that in society system in a village, mutual interaction between an individual and its society is highly intensive, that every action taken by an individual will affect its neighborhood and vice versa. According to the participants, positive support from the closest people will motivate clients to take the best decision and think rationally in coping with the side effects that may arise. In the contrary, a family will be able to accept side effects that might appear if support has been given from the beginning. *"…It's very important for the whole family to support. Her husband has given his support. If the wife wants to join but her husband is not supportive we will not place the contraception. Her family could influence her, especially parents. That's how it goes in villages, if one thing happens the whole member of family have to involve…"(participant in Cilimus)* A client who is able to calculate is also considered as a good client. The calculation is not needed merely before the placement time but also the time after the placement. It takes account of anticipating sudden expense that might be needed to cope with side effects occur, like joining the insurance program. This method has been applied in Kuningan, as asserted by participants: *"…so those who have understood, who felt okay, accept any kind of side effect. That's what makes us relief. We wish that they didn't always put the blame on us if something wrong comes up. Nowadays people have understood, right? There's insurance, right? A FP insurance…if we offer the insurance and they take it we feel a bit relieved in case of something happen. Because if they have to be hospitalized and that is caused by FP program they want it to be free of charge…at first there were many kinds of insurances…there was a FP insurance so the fees will be paid by the insurance company although not all in full…it depends on how much they pay out in insurance or the premiums…"*	

Table 14. Ideal-type Midwife

West Java	Lampung
Friendliness is one of personalities from *bidan* that is required by most participants. Moreover, for the participants, friendliness is one skillful package needed to break the ice between the *bidan* and clients. Approaches explained varied from one to another, however in general all of the methods made to create warm atmosphere inside the examining room in *Puskesmas*. Participants in Kuningan chose one of the methods as stated: *"…[behaving] politely here means, just like ibu Susie has said, we do the preparation first so before we place the contraception …we ask them to check their weight, check their blood pressure, then we ask them to lay down to be checked using stethoscope… we do it while we are chatting with them politely…"* Familial approach in villages' cultural systems is the most acceptable approach. For that reason, a good *bidan*, in the eyes of the participants, is not only that who make them feel comfortable in the checking room/ examination room, but also able to make specific approach for community who has never joined FP program before. It is illustrated by one of participants in Ciniru. *"…so we do the chit-chat with the acceptor first, 'How are you, ma'am? How are your children? Are they fine? How's your husband? Is he fine?' You know chit chatting…after that we ask them, 'How old is the youngest child? Have you join ed the FP program? Any plan to prepare pregnancy', then they would answer, 'Yes, that's why I come here' now…finally [they tell us their purpose]…"* Meanwhile, friendly personality required from *bidan* has been internalized conceptually and becomes a principal to improve the quality of *bidan* service to their clients. The concept is called as 5 S, *salam*-say welcoming words, *sapa*-greet, *senyum*-smile, *sabar*-be patient, and *sopan*-be polite. From their confession, it is known that this principal has been applied in daily interaction with clients, although in practical *Puskesmas*' condition often takes	Two things are of most importance to the midwives when they describe their ideal-type midwives: charity and technical ability. They often define an ideal bidan ("bidan teladan") by pointing to the skills and knowledge dimensions first. However, the skills in communicating with clients are also considered important for a good bidan. *"A midwife should have sufficient skills and, perhaps, her knowledge and skills should be balanced. She can acquire these through trainings and books."* *"A midwife who is skillful, smart, and accurate in her decision."* *"It would depend on the ability. Perhaps a midwife should also be friendly. If she is rude the patients would flee."* *"What can you say? A midwife is supposed to be on-call 24-hour a day."* *"For me, it doesn't matter who the patient is. Whoever asks for my assistance, if I could help, I would gladly do it. Our only concern is the safety of the patient. I don't care whether they will pay or not."* *"A midwife should be altruistic. It should be like that although not every midwife is like that. There are some who are not charitable anymore. They expect to be paid every time. Actually, we have to realize that even the poor should be assisted."* *"We have to treat both the haves and the have-nots. We have to assist those who need our assistance."* Whenever applicable, midwives are also expected to become a model, particularly in family planning and general health practices. *"A midwife should practice family planning*

highly vigorous people. In any case, this concept has to be preserved for it is considered as a part of *bidan'* skillful system which are internalized by the *bidan* as a part of professionalism values.

Another finding inquired from participants in Kuningan indicates that *bidan* has tried to develop standard of proficiency outside legal-formal limitation, which means the approaches mentioned come from modification in practice and is not merely something learned theoretically.

"…because it is like this or that so I just kept silent…I let them [the clients] to do the talking…they talked and talked until they felt satisfied…they even talked about their personal lives…but we kept their secrets…that's our ethic as their bidan… so it [keeping the secrets] make us trustworthy…so they are very open…and they need to be [open] …now we use that kinds of method or trick nowadays…"(a participant in Kuningan)

Enhancement or modification in the field is done by participants in Cilimus as well. It can be viewed from their opinion that concept of '5 S' can be learned spontaneously, just like theoretical concept contained in 'keeping secrets' as an ethical code of their occupation and their preparation to be able to provide public service regardless the time. In other words, participants in Cilimus understand perfectly [*bidan*'s] position as 'service providers' just like they understand values practiced professionally.

"…[we] should have broad knowledge especially when it comes to our jobs, and we have to be able to perform our jobs professionally/ we should be patient…well we have to apply at least "3S"…it's spontaneous, for {say welcoming words, greeting} and smile…/So in dealing with the patients we have to apply that "3 S". We are open but still we are able to keep secrets/ we can handle or follow up clients' complaint so we are dependable, ready at service at any times…bidan who perform duties in the village, especially, should be ready whenever they are needed…No matter what they are doing patients come first, right?…"(a participant in Kuningan)

herself, so she could be a model."

"Yeah, I told her that most effective contraception method is spiral. The risk is low and menstruation can remain regular. The fact is I have been using IUD myself, so I can say something about it."

"Midwives or other health providers should provide an example to the community. They should be models. If we expect the community to join family planning we ourselves should join family planning. If we expect the community to keep their environment clean we have to keep our own environment clean."

In general, the midwives are proud with their job. After all, in the rural areas, midwives are considered part of the community leadership. They are proud to be an important part of the efforts to keep the community healthy.

"They wanted to move me to the Health Department Office, but I refused. I told them that I like serving the patients. In the office I would only face books. I like meeting the patients."

"The existence of bidan in the community is recognized. The community still listens to whatever we say."

"As long as she is an acceptor she's still our responsibility. She might have some complaints. If she uses pills she might have acnes. If she uses injection she might get irregular menstruation or acnes, too. These remain our responsibility while the patient is an acceptor."

Because authority and expertise play a great role in midwife's sense of pride, they often measure themselves on technical ability. As an illustration, a midwife told us a story about how she learned how to install a new type of implant and that she did it well without much training.

"My recent experience with contraception is with implants. The one that lasts five year is

Cilimus) In relation to professionalism idea platform wanted, participants judge that there is another step or stage should be made by a good *bidan*. The stage is derived from an opinion that it is ideal for a *bidan* to comprehend the procedure of each medical action taken. *"…they don't have to force us to provide them excellent service. We follow the medical procedure. But the way to provide service depends on the patients' personality. In essence, patience is required…"* That kind of analysis indicates no less than two things; firstly, an understanding of proper medical procedure will be accompanied by the safest implication consideration for clients. Secondly, clients' subjective consideration, that/which fits his wish without further interference from *bidan*. A good *bidan* will always bear those two things in mind. *"…you can choose which one you like I don't want to force you…these are the advantages, so we tell them the advantages and the disadvantages so they choose this want, "Ok ibu [bidan] now I want to get permission from my husband first. We tell them," it would be better if you ask your husband to come here…" (a participant in Kuningan)* Aside from medical procedures followed by *bidan*, there are also non-medical procedures. Although they are only considered as supporting facility nonetheless their existence play an important role in the success of health-care service provision. This fact has believed by participants as an effective method to build active communication between *bidan* and clients. For that reason, the participants think that a good *bidan* is one who always includes a counseling method as a part of the program. By providing counseling, clients will have greater opportunity to see problems lie in FP program and, have time to make a decision. The following quotations exhibit ideas about a good *bidan* from the participants: *"…in the service provision location just like [we did with] the former clients, we explained about the disadvantages and disadvantages [of contraception] in which they have to choose*	*Norplant. This new one is never supplied here, it's called …. [unclear, might be Implanon?]. Recently, we were involved in inserting this new one, without getting a training first, with good results nonetheless. This new method lasts for three years. I and another midwife assisted first, we observed first, and then we managed to do it ourselves … The pleasant thing is like I said, Sir, usually we were trained first, introduced to the method at the head office, got a chance to practice over there, and then we can do it here. But this time it was direct, we observed and then we did it hands on."*

the one they like…"(a participant in Kuningan) *"…so when it comes to injections we probably have a little problem. But when it comes to IUD, we have to give such a long explanation. It's not as easy as injections or pills" (a participant in Cilimus)* *"…but before they join [the FP program] they are very likely to follow the counseling session. You'd better do this. Ibu bidan tell me to do this, so we have prepared our mental, so now we provide counseling so they will not worry in case of malfunction occurs…"(a participant in Cilimus)*	

Table 15. Obstacles to be a good midwife

West Java	Lampung
There have been several things that participants think as part of direct obstacles in their effort to be a good and an active *bidan*. Some parts of it, just like experienced by participants in Ciniru, has been described before, is social-cultural, like the language. In relation to cultural factor, one of the participants in Kuningan believes that a calm atmosphere is very conducive for clients to be active. Openness should be facilitated by providing a proper counseling room and creating comfortable atmosphere for clients and *bidan* to communicate. Meanwhile, other obstacles faced are those of operational problem, even though some of it includes the distance of remote villages that are difficult to reach. Some participants expected government to provide transportation for them. The expectation is considered reasonable enough to improve quality of service provision for society. As the comparison, participants see the facilities of motor vehicle can be utilized by PLKB officers in sub-districts. *"…then finally vehicles, BKKBN officers are given motorcycles, but we don't (laugh)./ please suggest [the government]… we are the ones who serve acceptors, who (not clear), how come they give the vehicles to BKKBN [instead of us] (laugh) (a participant in Cilimus)*	The providers in group discussions and in interviews are quick to blame the clients for any failure they might face in providing health service, often pointing to the low socio-economic status of their clients or even to the possibility of their clients to lie about their condition. Very few problems with themselves are mentioned in the discussions, although in interviews there is an admission that midwives could have their own personal or family problems and those can lead to impatient behaviours on their part. In general they demand reciprocal friendliness in their encounters with the clients. *"We expect the patients to be … uh, honest. But we have to be strict with the patients, "If you get pregnant do not blame us, okay." We should have a form for the patient to sign. For injection, if they refuse to do a urine test saying that they have not had sex recently, it should be on the signed form. If it turned out that they had sex, we cannot be blamed."* *"So do the patients, they have to be courteous, too. Sometimes we are required to be respectful, while the patients do not have to. Of course it is our duty to offer a friendly service, with all the information so that the patient can understand. But, at times we are*

Participants in Kuningan revealed few socio-cultural obstacles as well. However, unlike those faced in Cilimus and Ciniru, Participants in Kuningan see the lack of social support to clients as their own problem. It is often found that clients postpone their involvement to join the FP due to their husband minimal role, even though the *bidan* has tried to motivate and guide clients to join the program. Accordingly, the lack of husbands' role creates a barrier for clients' decision-making.

"…often the husband does not know if his wife has delivered a baby. The wife calls her husband only if or after the baby has been delivered safe and sound then. Sometimes, the husband has not come up to see the baby although her wife has delivered a baby forty days ago so we tell them that if they want to join the FP they have to wait for their husbands [to come or to ask for permission]…"

"…so that is also considered as a barrier…a barrier from her husband…so sometimes we have to wait for her husband for over two months but theoretically after two months we can not provide them FP service anymore because there is a chance to have further insemination now that's their loss…so the barrier comes from her husband…"

Another factor categorized as a socio-cultural barrier is the rejection of FP from the minority of people who think that FP or certain health check or examination are prohibited by their religion. Special approach has been made, but this kind of barrier is not easy to overcome.

"…people who think that FP program is prohibited by religion are only exist in the village where I perform my duty. There are three families who refuse to join FP…they're the barriers/ they have so many children. The PLKB and us have never succeeded in coming into their houses…it's really difficult…even when they are pregnant they do not want to be checked…they never had their kids immunized… they think taking their children to Posyandu is prohibited by God…"

"…I don't think the bidan face barrier at all…it's just that …the barrier is just that we are unable to pursue our study…not yet/ obligated to do more than that while the patients are not."

"I only said, "Mam, next time please listen to my advice, now you are already pregnant what can we do?"

"I have [ignored a patient], I admit that I have done so. But it really depends on the patient. Sometimes there is this patient who asks questions but it seems she's not merely asking questions but more like being intrusive. Sometimes there is this patient who is cocky, she would ask for medicine that is not based on our examination but you can say she writes her own prescription."

"A1: As an example, she uses injection. We tell her to come back on the second of the month. If she adheres to our instruction [perintah] she should be back on the second, right? At times she delays the visit. We ask her to come on the second, she comes on the third. Such things could cause pregnancy. If she comes back late and she gets pregnant, she might blame it on us. That's why communication with patients has to be clear and our advice should be followed. If not, it is her loss."

"A2: She does not abide to our advice but she demands us to do things. That's how it sometimes is, sir."

One problem that is often complained about by the midwives is when the clients do not submit to their authority and instead listen to other sources, such as neighbours, husbands, or members of the family.

"It would be different if she listens to others. For instance, the injection method, after the first shot some women can just stop menstruate, while others could menstruate up to a month. Some even menstruate until three months, up to the time she needs the second shot she stills menstruates. Now, she does not consult it with us even though in the counseling if she has anything unclear, if there is anything bothering her she could ask the midwife or

haven't been permitted yet…improving manpower/ I think there is no significant barrier… it has become our duty, it has become our routine to serve people with different personality…"(a participant in Kuningan).

Improving the quality of manpower enlightened by participants in Kuningan has raised into the surface and turned into an important theme in Cilimus. Participants think that the barrier is an internal one in which the will to improve has to face several obstacles. As stated by participants in Cilimus, aside from cost, restriction in age is one factor which smaller the senior *bidan*'s opportunity to deepen their knowledge through formal systems.

"the cost/ yes the cost to expand our knowledge/ one thing is patience. Human has limitation in patience, right? Yes we test our patience. About knowledge maybe we have to improve ourselves…we have to pursue higher education…and we don't have greater chance [to continue study] because those who graduated from gynaecology (kebidanan) academy and who are over thirty-five is put on the top list."

Another thing that limit their chance to attend seminars improving their skill and knowledge is their playing double roles as *bidan* and housewives.

"We would like to attend seminars regardless their location but we have our own barriers like children or patients who come to our house. But we want to improve our knowledge. We can attend the seminars held in our reach/ knowledge is always in progress, right?…we are afraid patients would think negatively if we are always away from home.

However, facts found in field revealed a slightly contradictory opinion about opportunity to pursuing education and training for senior and junior *bidan*. Participants in Cilimus think that their "senior" age lessen their opportunity in improving knowledge. Meanwhile, participants in Ciniru admitted that their chances to improve skill through formal ways are often limited by the department in charge. Participants revealed that budget from

other health providers. She should not ask her neighbors. If she does, the information could be different. For example, while in the market she could chat with her neighbors and get her information there. "Mam, I am scared, they said it is a cancer!" That's why she shouldn't get her information there. Her information source is wrong. She should come back to those who know better, whether to the doctor or to the clinic."

"As for me, she shouldn't just listen to the community. For example, she is bleeding for a week and her friends say there is nothing to worry about. I wish she would just come to us. After three weeks, after her face looks pale, she would come to us. Sometimes when you take injection you menstruate a lot. Only after she suffers anemia, when her face looks pale, would she come to us. Why don't you come earlier? You don't have any money, huh? Over here we do not ask you for money and you know that. No, my neighbors said there is nothing to worry about. My mother-in-law said it is okay, it is always like that. I said, but I am the midwife, you shouldn't listen to others. You could just come here, it is not far from your place."

"I am the midwife, I am the health provider, right? You are supposed to ask me."

Like any field extension agent, the midwives tend to think that they have a lot of difficulties with clients of low socio-economic status. So most of the stories about these "bad patients" are based on their experience with the low-income clients who, of course, are actually both "at risk" and "in most need."

"These social safety net (JPS) patients are difficult to serve, and the services that fall under JPS are limited, but they expect the quickest and best service."

"They always want to be served quickly and want a good service that is similar to what others get. Of course, it would be different. JPS does not provide everything."

government to finance education programs are unavailable which lessen their opportunity to be on the list. Speaking of the program, one of the participants claimed that he was willing to pay with his own money even if such programs were held by private sector. They assumed that their one-year diploma education background does not meet the requirements anymore, whereas their job requires better skill and knowledge. The following statements are those from Ciniru.

"…rich in knowledge is broad right?. .the trainings are some kind of further education, the barrier is that we haven't got the money to cover the cost of study…"(a participant in Ciniru)

"…well.. so far there has not been [any trainings or further education programs] yet because it is [the selection] takes time to process], if there is [training or further education programs] we would like to join even if it is held by private sector. Like the last time was only partly done…well u know that speakers which are all seniors.. if it is possible we are willing to pay them ourselves, so when it comes to knowledge we are willing because that's for our own good, so if patients complain [something] we don't have to take them to the sub-district head but we can handle them here [in a village]…"

Another important issue is the significant obstacle *bidan* faced in counseling session with the society. This problem arises from scheduling of program that does not match people's working hours. Nonetheless, participants admitted that the blame is not in people side, it's just because there is no agreement between scheduling in *Puskesmas* and village-visiting hours. *Bidan* are only able to do counseling session after finishing their serving hours at noon, but at noon people are working in the garden. This kind of technical obstacle testing *bidan* patience to the limit. The following are statement from participants in Ciniru:

"…sometimes we have to understand [be sensible], if people already have other thing to do, other meeting to attend now when we arrive to give counselling session there are not many

"If, for example, she comes to the clinic, we have to analyze her first, to ask her questions. We ask her the number of children she has, what contraception she ever used, and what her education level is. We have difficulties with those with patients with a low level of education. It is difficult to explain things to her. If she is of higher level of socio-economic status it is easy for us to explain. Like this mother, she has a lot of children and she is fat. It turned out that she has a heart problem or something like that so we offer contraception like spiral to her. I think it is okay to lead her into a certain method."

"It is a matter of socio-economic. If implant is not free maybe no one wants it. In the private clinic they charge 100,000 rupiah for it. It is only wanted because it is free. You see, the people here, they cannot even afford the implant removal fee. It is true. One got pregnant because her implant had expired; it had been used for more than five years. I have a 50-year old patient with an implant still installed, even though she does not menstruate anymore. She does not want to remove it because does not have any money."

Another possible source of problem that could hinder the communication between midwife and her patient is language. It could be because they speak different languages or it could be that their levels of language use are different.

"I have told her that she should not have sex before two weeks after the installation of IUD so the thread would be softened. However, she did not seem to understand me. Her Indonesian is not fluent and I do not speak Balinese."

"Maybe besides knowledge our communication style is also important. If we use difficult language maybe the patient would find it hard to understand us. If we use the term IUD, perhaps the patient does not know that we are referring to spiral. If we say "inserting implant" they might not understand that we are talking about [susuk, implant in Indonesian]."

people showed up…it take us a long time to get there…" *"… if we want to give them explanation for example about siaga-awareness then we have a hard time in planning the best time to visit the village because it's difficult to interrupt them when they are working…whereas our working hours is from morning till two o' clock in the afternoon…but that time the people are working their paddy field so we reschedule again and again…"* Due to remote distance from their houses to Puskesmas and counselling session schedule that does not match clients, only few attend the meeting. For example, about 'Desa siaga-aware village' bidan has to adapt their time to people in villages and give counselling session after six o'clock in the afternoon that means interrupting their time with their families.	

Table 16. The Role of Midwife in Decision-making

West Java	Lampung
The knowledge on the long time benefit of using FP as a mean to control birth interval has been understood by many people. This fact shows there is a shift paradigm from traditional to modern. The idea of having a small-planned family has been gradually internalized into national planning. "…if we have many children make us busy (repot), while we have to think for their education, health, and others. So, we have to tell clients that having many children do not mean having many fortune, but instead having many difficulties…" According to participants, if clients have knowledge and awareness in the advantage of using FP, they will have a good decision-making. "… now, we don't have to push them to join FP program, it is now their own will, and they will look for us …" However, some *Bidan* also mentioned the role of husband and close relatives that can	The respondents almost always acknowledge the right of the client to make the ultimate decision, although there is one case where the midwife proudly told us a story of how she inserted a spiral into a woman without her consenting it, or even knowing about it. Hopefully, that is an exception. Very often the respondents tell stories that indicate how significant the role of the midwife is in the client's decision-making process. Cost is often a significant issue in the decision-making process and the midwives say that they always consider that aspect when helping clients to make their choices. *"First, we explain the affordable methods and explain their side effects … If we recommend implants while her socio-economic status is low that would just create a problem."* *"What should I say, we are offering the service so we know better than the patients. Unless, of course, the patient happens to have the same educational level as us, like another health*

influence clients' decision-making to join FP program. *"… sometimes we have to tell the husbands as well about the benefit of joining the FP, as they are the first persons who have influence to our clients. Our clients often told us that they are forbidden to join the FP as their husband feel the difference when having a sex with them"*	*provider but with a higher status than ours."* *"For example, there was this mother named Tri. I forget her full name. She had her first child and then she joined family planning. At first, she did not want to, she was afraid. Finally she was willing to follow my advices after I provided here with some information. The fact is midwife is an important factor in decision-making."* *"The service was attended by many participants, about 35 people. Many came to have their 5-year implant removed to be replaced with this 3-year one. Because it was a free service so many people came. It just happened that their current implant had expired. Out of the 35 only two asked for a spiral.* *"The decision remains with the patient, although we have to offer explanation first."* *"The mother I assisted yesterday seemed so certain. She has two children, all grown up; the first one has even married. She married at a young age. So she was not even 40, perhaps about 36, about my age. First, I removed the six capsules and I asked her, "How old are you, mam?" "I already have a grandchild, you know," "Wow, but you are so young!" "I married when I was a small kid, so now I already have an in-law, I have a grandchild, while my second child is still a bachelor." In essence, she does not want to have anymore child, two is enough. So after the 5-year implant is removed she put the other one. It is so happened that both times she does not have to pay anything. She was happy, "I always got it free, Mam.""* *"If after they try it themselves they find the contraception as we say it is they will keep it. I cannot say for sure whether it will or will not hurt. They have to try it for themselves. If they have not feel it for themselves they cannot prove what I say."* *"After she had the IUD for five years, she came*

	to me to take it off because she wanted to be pregnant again. After giving birth, she asked me to insert another one. I don't have to tell her to. So, it is based on her own experience." *"I ask them, what do you prefer, I will give some considerations, depending on their condition. We cannot push them, it depends on, one, their mental readiness, are they firmed in their method choice and, second, whether they have the fund for certain methods. For example, to use implant they need some money, do they have the money?"* *"Yes, the decision is in their hand. We only advise them about each method. Injection is like this and pills are like that. The decision remains with patient. We don't push them to select something."* The midwives also acknowledge the role of community leaders in convincing community to join family planning or to use a certain method. *"Often they need to be told by the village leaders. Basically, the women would obey what the leaders say."*

Community Leaders

Table 17. Ideal Clients

West Java	Lampung
According to ToMa, a good patient is one who can communicate with *bidan*, inquisitive about health, and courageous. A To Ma group in Kuningan believes that a patient has the right to know the advantages and the disadvantages from the contraception. Another participants thinks that a good client is a client who abide by advices and suggestion given by *bidan* and does not believe other people whose explanation is not able to be responsible for. Other thing beside that is open attitude, and be honest in telling [*bidan*] her condition. *"and she should be open…for*	When asked to define a smart client, nonetheless, the leaders do emphasize on client's active involvement in health care. Like respondents in the other groups, the leaders also said that patients should listen to the advice of the health providers. The compliance dimension is also important to the leaders in defining a good client. So, the willingness to listen to bidan's advice and carrying out what is asked by the bidan are important characteristics of a good client. *"A patient is smart and active if she listens to what the health providers tell her. For*

instance…sometimes there are clients who had joined the program get pregnant/ they said when they never had sexual intercourse with their husband since they used contraception so they put the blame on the bidan…so don't cover it up/ be honest/ obey what the bidan has said/… if the bidan said that they have to use IUD then they'd better obey it"

" to me [a good client] does not mean that she has to obey whatever the bidan said. But the one who wants to listen and follows the program made…one who trusts the bidan and other people who understand about the matter. Don't trust the people who don't know about medical problems…/ who obey the rules made by our officers, that's a good client.

ToMa's group in Cilimus sensed that the term 'a smart client' does not fit FP acceptors well. The suggested the term "PF proactive", but other participants think that the term will only be referred to FP acceptors while those who are not FP acceptors do not included. Then somebody suggested the term "*pasien teladan*- a role model patient" but other interlocutors disagreed because the term 'patient' does not always mean patients in hospitals but sometimes mean patients of ***bidan*** The last term recommended is "***akseptor prima*- an excellent acceptor.**"

"well… "proactive KB" is okay/… one who wants to understand…what is it nowadays? Oh "KB mandiri-an independent FP" now that's still new [term]. "proactive KB" is pretty good [term]/ so the patients are suffered from serious illness… patients here are not only suffered from serious illness…[the term] "KB proactive" means it is [the problem] is specific"

"[the term] 'patient' is too general, those who come to a hospital are called patients/[those who come to] midwife/ for FP participants is 'akseptor-acceptor' right?".

"the most important thing is comprehension right?/ if we use the term 'cerdas-smart', it does not match….too superior …maybe it match educative matters/and 'akseptor prima- an excellent acceptor' is alright…"

As stated by them, in reality there are a lot of *instance, what's not to eat. If they don't obey it their condition could get worse."*

However, the leaders, perhaps more than respondents in the other two groups, emphasized on the need for the patient to play an active role in a treatment situation. They mentioned such active behaviours as being able to ask the bidan of what is going to be done on her or being able to share their conditions with the bidan. Being sufficiently knowledgeable about the available contraception options is also mentioned although leaders did not emphasize entrepreneurship on the part of the clients in seeking information outside the clinics.

"A good patient listens to what a doctor or a health provider tells her, but does not just take it like that. She has to ask about the medicine given by the provider, about the side effects, about how to administer the medicine, and so on … In essence, a patient who follows her doctor's advice but who also acquires knowledge about what medicine she is taking and the effects of the medicine. Economy wise, the patient is smart if she knows that there are generic drugs in the market with the same quality with the non-generic types but with a better price. She should also be able to decide when to see a specialist or a general practitioner. It will be cost-efficient if a patient knows exactly when she needs to see a specialist, which is usually more costly than seeing a general practitioner."

"Specific to family planning, she should know the benefits and side-effects of the contraception methods. A patient should ask her midwife about what the contraception offered."

"… a patient who is able to explain the symptoms of her illness clearly and in details to the health providers so that they can be more easily give the correct diagnosis … Perhaps, also obeying all instructions and be discipline."

"A patient is smart if she can explain the

clients who do not understand much about FP service provision and most of them merely realize that FP is important. The realization of the importance of FP can be inferred from the negative experience that having too-many children will cost them troubles. This knowledge is also obtained through religious counseling. Yet, many of them do not have profound knowledge about the contraception itself. According to one of the participants, clients' motivation in joining the program is not economical; instead it is because they want to be healthy both spiritually and physically so they can be active individuals. Nowadays, FP program is their first priority in their lives. Because by joining FP program they are able to fulfill their needs of food, clothing and housing. For them, FP has become a primary need. Participants enlightened the fact that a lot of housewives save their money to join this program because they want to stop giving birth to their children. *"…well you know their thinking…so sometimes they are worry about the fees and everything."* *"for some people, housing is their primary need…there are primary need/secondary/ … even though there is a chance of malfunction in contraception but to me it is [still] badly needed/…the concept of the basic needs are first, clothing, food, housing and…FP is the fourth/ …to me it is the contrary, since I have fulfilled my needs of clothing, food and housing, FP becomes my first need/priority."* *"it looks like [there is] a shifting of concept of basic needs…for people in general… the first one is fulfilling their basic needs. If you see it from the primary and secondary needs FP is the third. Primary needs is dominating needs but not a hundred percents yet. They just need it…but they don't realize it…"(a participant in Cilimus).* However, in reality, ToMa realize that a lot of patients do not have the courage to ask bidan questions. One of the reasons, according to them, is because their lacking of education and economic condition. ToMa thinks if the patients had more money they would have	*symptoms of her illness, but also brave enough inquire about his/her illness to the doctor. She is a layman, but she should be able to ask the provider "what am I suffering from?"*

more courage.	

Table 18. Ideal Midwives

West Java	Lampung
According to the community leaders, an ideal *bidan* should be one who informs (patients/clients) the side effects of the contraception, both the advantages and the disadvantages of the contraception. Aside from that, a *bidan* should possesses the following characteristics like friendly, patient, cheerful, open, warm-hearted, are willing to take good care of the patients, attentive to clients' complaints, kind, are willing to distract patients concentration when giving an injection, are willing to give maximum facilities, responsible, experienced, who are willing to keep their voices down because people are sensitive, are willing to check/examine meticulously. The most important thing is that the *bidan* gives equal treatment to rich and unfortunate patients. A good *bidan* should also give patients information as much as possible. According to the community leaders, in reality sometimes the *bidan* does not inform clients about the consequences and the side effects of contraception usage. *" …in my opinion, a good bidan is one who is probably open …it means…they give clients [information]…/…she is especially a good a civil servant…it means…they should be open whatever the complaint is…/ it is hoped that the bidan notify the advantages of using contraception [to us]/ they can do an interview session so we don't feel hesitant to join the program/…we would like to have a friendly bidan…an open individual …when I take my wife to puskesmas the first thing I expect from a bidan is her friendliness if she is unfriendly…she doesn't answer our questions…I will come back home/ experienced, that's for sure…/ a senior one…/ the bidan can guide other bidan in duty/ particularly in terms of serving clients in giving birth-that's what the society look for [in a bidan]…/ but the personality comes first,*	An ideal bidan is defined by their attitudes toward the client and their skills—both technical and social. The leaders expect the providers to be available to all clients regardless of their financial status. A parallel to their expectations of the clients to be obedient, the leaders expect the midwife to see to it that the clients are compliant. *"Health providers should be firmed and strict. For instance, sometimes the patient is told not to eat sour food but she ignores it. In this case, the provider should be strict to the prescription."* Just like most clients, the leaders judge midwives on her willingness to help everybody, especially the poor. They expect the midwives to treat everybody the same but at the same time they expect the midwife to assist the poor. *"She should be exempting the patients who cannot afford the medical cost from paying the full price."* *"Firstly, a midwife should understand her patients' condition, meaning be compassionate of their ailment as well as their financial ability, and secondly try to lift the burden of those with lower economic status. For example, a midwife should not think twice to refer the patient to a doctor if the patient needs an operation to deliver her baby, even if economically she could not afford the medical cost."* *"A midwife should always be a standby in assisting any time needed."* *"One who never sends away patients coming for a treatment, is helpful, and highly educated*

friendliness [is important]/ a bidan should treat all of their patients equally regardless their economic condition."

Nevertheless, another group of community leaders affirmed that the description of an actual and recent *bidan* has almost matched the ideal description. To describe a real/actual *bidan*, they mentioned one of the most popular *bidan* in each of their sub-districts. Yet, nowadays people trust a senior *bidan* more and they feel worried if they are served by junior *bidan* who they think has not enough experiences.

"if the bidan is a beginner [we are] worried …/ [let me give] an example, if people are served by the young and new bidan they worry so they look for a senior one.

At first, a community leaders group in Cilimus proposed the term '*bidan teladan*/a role model *bidan*' but then they preferred the term 'professional *bidan*', to cover all of the characteristics mentioned above, knowing that a *bidan*'s work is closely related to a human's mental and moral state.

"so it could be from the mental, from the moral state/ so model for everything/ I expect a bidan to be professional …I can't be a role model / so more as a professional instead of a role model/ it usually involves mental and moral state…""

so they can communicate their treatment to the community. They can give guidance right away."

"If there is a poor patient comes in earlier, the midwife cannot allow a wealthy one to receive treatment first. A midwife should have a sense of justice."

To the leaders, midwives should be a leader and a friend to the community. They should be good-natured and pleasant to work with. Several times they also mentioned that midwives are expected to be able to handle difficult situations and to create an atmosphere that relaxes the clients.

"She should handle her patients with calm, she shouldn't be perturbed, even when the patient is critically ill."

"An ideal midwife is one who is able to inspire hope, to encourage patients—with some suggestive method—to have the will to survive, to be healthy again. She should be attentive and patient."

"While treating patients she can give them a peaceful mind, can project beautiful images of things, so she is not scaring them. I know such a midwife, she's rather fat but she is healthy. Her name is [name of midwife]. She works at the Yoso Mulyo clinic. In this district there are a few of them good midwives, but this one is even better than them."

"We see their motherly attitudes, patient, and the service is good. Most importantly, they are always smiling, humorous, telling jokes to clear away the pain."

Of course, skills are a part of the leaders' definition of a good midwife. As an illustration, they mentioned how a certain midwife does not resort to "stitching" when assisting a delivery; this becomes a part of the reputation of the midwife. Midwives are also expected to be more heterophillous, that is, acquiring more knowledge and expertise beyond pregnancy-related knowledge and

	skills. *"She should be able to assist patients keenly and skillfully. As soon as the patient arrives the midwife should immediately know what to do.'* *"There was this midwife in Banjar Sari, she was assisting a delivery and it turned out to be a difficult one. I saw her quickly reported the case to an ob-gyn who later helped the mother. Thank God, the mother and baby were saved. That is what I like, the midwife was fast."* *"...A midwife usually encounters some difficulties in helping a first-time mother to deliver her first baby, and usually has to perform stitching on the patients. But some people said that this particular midwife never had to stitch her patients."* *"Nowadays, the community needs more than delivery assistance. For hypertension, I know we are not supposed to see the midwife but at least she should be able to administer first aid assistance."* *"In my opinion a good midwife, aside from being good in her service and treating everybody the same, she should not be sloppy. Sometimes they just give out medication or give shots to the patient, while the patient does not know whether the shot is necessary. They cannot just give a medication and ask the patient to go home."* *"An ideal midwife is one who has a broad insight [wawasan, commonly used to refer to knowledge]; she must understand the psychology of the patients."* *"Apparently, the essential thing is the midwife should always expand her knowledge, she should always be willing to learn."* To the leaders, midwives should be a leader and a friend to the community. They should be good-natured and pleasant to work with. Several times they also mentioned that midwives are expected to be able to handle

	difficult situations and to create an atmosphere that relaxes the clients. *"In serving her patients she, like we say around here, does not have ants on her lips, she is smiling all the time. Even though she is tired she still offers her service in a friendly fashion."* *"A good midwife is the one who is smart, can communicate something quickly, with smiles. She uses simple words to communicate, and she can communicate clearly and to the point."* *"An ideal midwife is one who is willing to listen to patients' complaints patiently, and regards them highly; so, she should be patient and pleasant."*

Table 19. An Active Community Leader

West Java	Lampung
According to ToMa, an ideal community leader should be highly educated, creative, communicative, helpful, has broad knowledge, talent, and care about the society. Besides that, ToMa should be the one to ask questions, to complain, to tell the problems, they should have the inspiration to create clever society and has plenty of ideas. A group of ToMa in Cilimus revealed that an active ToMa is one who is willing to explain FP problems through counseling in gathering events, such as KNPI. Participants also recommended FP seminar for teenage, for example seminars about free and healthy sexual intercourse since teenage have not understood about sex perfectly yet. Although there has been school counseling, it is not considered enough. ToMa are expected to help cadre's jobs in formal and informal events like arisan held by housewives. PKK and religious leaders should ask and motivate people to join this program, although they realize that the two types of ToMa do not serve function as that of *bidan*.	The leaders have high expectations of the community. They also place importance on the community initiatives, riding on the spirit of the reformed era. Most of the stories, however, are not about family planning issues but on health in general. The leaders seemed to find it difficult to think about things to do to improve on the family planning care services. Here, again, the emphasis is on the community initiating their own development and taking the health matters into their hands. Very few, if any, statements were made on the structural issues and how the community can or should do something about it. *"All parts of the community are supposed to be involved but so far it is only the Posyandu and Dasawisma that are active [in health promotion]. There is limited participation the part of the youths. Posyandu is only attended by about 60% of the potential clients. I wish it were 90% or even 100%. In the future I would hope that more youths are involved."*

"they will only be the one who ask people…who motivate them…what is it?…society then the society is also one who like counselling…/ maybe we are the ones who motivate and ask them to join the program yet the bidan are still the ones who explain". Another group of ToMa also expected that the programs arranged by the other ToMa should be done totally and continuously and is followed by a familial approach. *"[we] support the FP program…for instance this community leaders [near me support the program]…and I as the next generation in KNPI events and everything, I can present the other advantages especially in terms of reproduction/ yes I think seminars for teenage is necessary …if they have been informed [about this]…hopefully…"* However an ideal description does not always matched facts found in the field. One of the participants think, not all of the ToMa motivated their people to join FP program. However, PKK and religious leaders did not approve of this opinion and they assumed that they had served their function in motivating clients/society. *"[the help of ToMa] is quite dominant…for example in gatherings or arisan/ Especially PKK leaders. They are very helpful. They are usually active in Posyandu…"*	*"Perhaps as an illustration of an active community we can see the community in model village where when we tell them to use toilets they do it. Such a community cleans its neighborhood every Friday. This is what they do within government programs."* *"Creative in establishing health programs. Because this is no longer Suharto time there is no government assistance for such programs so we have to do it independently. I keep telling the community to do it, for example, to maintain their own garden. "* *"In essence, the emphasis should be on the realization of the community itself that health is important. It cannot be merely because the providers keep telling them about it. "* *"An active community would be one that values health. Besides maintaining their body condition they should also eat nutritional food. They should work out diligently and pray more."* *"A healthy community means that individuals care not only about their own health … It would better if we do not only keep our neighbourhood healthy but also other neighbourhood."*

Table 20. Obstacles to Leaders Involvement

West Java	Lampung
A lot of ToMa have no clear idea what to do because the *bidan* did not teach them how to socialize the program so they are afraid of giving misinformation. *"ToMa are not active probably because they had not been told by the bidan about this yet/ they haven't got the knowledge/ they are afraid/ sometimes people are worried when it comes to their health and FP program/… so ToMa themselves are afraid [of giving the wrong information]. But if it is [the program]*	When asked about factors that can get in the way of their efforts to motivate the community, the leaders tend to refer to the typical problems of tradition, educational status of the community, and economic status of the community. In other words, the leaders did not readily see how their own efforts could be improved, perhaps because it is still unclear to them what their roles and responsibilities are in family planning decision-making. *"Well, some people here adhere to the*

connected to religion and…maybe they're the experts and they understand that it is okay [it is not forbidden by law of God]…"	*traditional customs. Some say that family planning is prohibited by religion. For example, if to a women should be inserted the family planning device and the doctor is a male, now that could create a problem. As a community leader we have to deal with such a problem."* "We might have provided the information but the individuals in question might not be able to afford it. There are actually JPS but sometimes they are unwilling to do the paperwork. Because of this condition they turn to traditional birth attendant."

Benefit from being smart

Clients

Table 21. Benefits of Good Clients to Community

West Java	Lampung
For people in one community (rural or urban areas), smart health-care clients can influence their surrounding. The client success as a FP acceptor will support the surrounding society to do the same thing, even though at the beginning they are not interested in FP program. Another advantage for the whole society is the changing of ways of thinking into step ahead. Just like quoted from participants in Cilimus: *"… the benefit for society is that it has no stupid people anymore, there is progress [in ways of thinking].."* Most of participants in Kuningan revealed that by learning from their own experience about contraception they can educate surrounding society in relation to side effects caused by contraception usage *"…then we can also spread out the news to everyone…informs…other people our experience…we know from the midwives…what is it/ what's that …I can explain…I'm not too foolish…according to our experience.."* Beside that, emphasis from one the participants reflects a belief that has been formed by	According to the clients the ideal clients would be a benefit to the community because healthy individuals can contribute better to the community welfare. Similar to other respondent groups, they also see smart clients as helping the health care system to operate more expediently. *"In my opinion, if the midwife succeeds in performing her tasks the community as whole would be more prosperous."* *Q: How do you think the community will benefit by having smart patients?* *A: Well, it is no longer difficult to tell the patient what FP method should be used because they know it themselves* *"The job of the community leaders would become easier."* The content of communications that the clients need is the type of information that they usually can get from the providers, including information about contraception methods and

promoting a particular contraception. *"… if I have to provide sample I will say that this is IUD…I know because I have used it…not because I'm smart or anything. You will feel hurt around this area…I said so because I've used it several times. I think I've used it six times…"* Apart from those experiences, there are several opinions that still need to be concerned in accordance to two parameters occur in society: the existence of system of value among society that tend to choose parameter of success from contraception by looking at the side effect b. the parameter of the success of the program is viewed from the quantity of the participants (instead of the quality of the 'clever' clients).	problems and symptoms related to certain methods. *"It was explained to me that if I use the injection method and it suits me I could grow fat, particularly when I don't get menstruation."*

Providers

Table 22. Benefits of having an active client

West Java	Lampung
Clients' characteristic that have educated themselves about basic knowledge before asking for FP service will be very helpful in the process of decision-making done by clients themselves. As for *bidan*, it will be much easier for them if the purposes in the information given, both the practical and the long-term one can be comprehended immediately. *"…there are always the advantages and the disadvantages and also the side effects. So they know what we are talking about. So they know what would probably happen if they use this or that. For instance, I already have two children so I would like to join FP program because having too-many children means trouble. So they know the purpose and the advantage of FP and the kinds of contraception that they are going to use".* For the largest part of participants, clients who are active in finding information or speak out whatever they feel will make it easy for *bidan* to take an action against it. Just like	To them the benefits of having a good client (as they defined it) are related to the completion of their work. A good client would allow their work to be completed expediently and simplified. They also think that an active client allow them to anticipate problems. If the clients are involved in decision-making they feel that the clients can be more confident in the providers' advice and that they are less likely to complain in the future. The happy client can even assist in advocating FP or a certain method. *"Well, you can say that. As an acceptor she can analyze her own body so when she has complaints she can express them to us."* *"As a midwife I will benefit because I do not have to explain to her repeatedly. So it is a save of time. If the acceptor is not smart, we often have to spend much time to give her directions …For example, if the patient is smart, we only need ten minutes to provide*

consultation scope described by participants in Cilimus and Ciniru.

"…then she ask us," If I want to use IUD, for instance, what are the side effects?" she has already known because she has asked then all we need to do is guiding and directing her [of the usage of contraception]. Since she has already known the outline she only asked for questions that make her doubt or confuse…so she thinks we serve her well…"(participant in Cilimus)

"… so if they don't speak out then we don't know their problems, but sometimes we ask whether they have got a contraceptive injection or not… so they have to tell us, if they just keep sleep then we wouldn't know…"(participant in Ciniru)

Besides that, a client who has done well preparation in joining the program will act wiser in dealing with complaint they feel as contraception side effects, and would not generalize the whole symptoms (for instance, usual stomach ache will not be related to IUD usage).

"…if patients have understood … it is easier for us. If they don't understand yet…for example if they get stomach-ache caused by starving and they thought they got it because of the contraception use, but the fact is they had been suffered from it all along before the placement…"

explanations, but if she is not it would take 20 minutes or 30 minutes that could be spent assisting others, or even for my own needs."

"So that they can be firmed with their choice. They are confident with their choice. The knowledge will facilitate the decision making process. We don't have to push them. If they do not have the knowledge and we select one method for them that would mean that we push them."

"The benefit is with their questions or complaints we can avoid letting them into a worse condition, we can detect earlier what the symptoms are. For example, they could ask, "Why do I keep getting this bleeding like menstruation?" We could ask them whether it hurts, whether there is pain. We could also consult the higher authority in diagnosis. We could suggest, "If you are not satisfied consulting with me, please see the ob-gyn." I suggested that because I also don't want something beyond my control to happen. Our examination here is not as good as the examination with the doctor."

"They can help by explaining the method to their friends. They recommend a certain method. So they are helping our information campaign."

The midwives, however, do not expect the clients to be overly active. In most situations, they think that patients could get the care and information they need even though they are inactive. In certain situations such as when the patients are concerned with side effects or a rumour they would ask a lot of questions.

"Questions about side effect are frequent. But without them asking we would provide the information. For instance, after taking the injection if there were blood spots she would ask, "In this month why do I menstruate twice, why do I keep getting it?" Obviously we have to provide explanation. Why do I gain weight, why don't I menstruate? These are all side effects, right. Many patients raised those questions. If there is no side effect, they would

	just keep using their chosen contraception." Inactivity, of course, does not necessarily mean that the patient would just accept anything offered by the midwives. In many situations, when the patient is a regular, repeat patient, it is business as usual. Patients could just come back for their next shot or their package of pills. *"What I usually find is the patient already made up her mind on one contraception. She would not consider the other contraception because she is comfortable with that one. In this case, she wouldn't ask questions."* Usually, when the patient comes in, if it is a repeat patient then everything goes as usual. If it were her first time, we would ask her in depth to understand her objectives. And then we give her information. If her education allows her to judge independently, usually she would choose spiral. We explain each method one by one, show her how they work.

Community Leaders

Table 23. Benefit of Good/active Clients

West Java	L:ampung
ToMa think that if the patient is active, they could handle something wrong at home themselves so they will not get nervous. It means that they could do first-aid themselves, are brisk and has own initiative to go to hospitals if side effects occur.	The benefits of having smart clients mentioned by the leaders are the same to the ones mentioned by the midwives. Apparently, a smart client is seen in a positive light, although it is clear from their statements that it is not very common to find one. In other words, smartness is still considered a unique characteristic, desirable but not expected to be practiced by many in the community. First, clients' activities are seen to expedite treatment and assist in getting the proper treatment or medication. Second, a knowledgeable client is also expected to help in spreading the information among the community. *"A patient could avoid critical illness if he/she could recognize the symptoms of his/her illness early, as it would be a great help for the doctor*

	to prescribe the exact medications and to treat the patient in time." *"One thing for sure, the program goals can be accomplished. If the community actively asks providers about health issues, surely the goal of healthy life can be achieved."* *"The benefit will be great. If we can encourage the community to be active we can be free of sickness and we are free from sickness our health status will be higher and so will our economic status."* *"I like to add something to the comments, the benefit of having a good client is that the patient can solve his or her own problems. It also adds to the patient's knowledge so it makes them more confident."* *"A patient should be willing to share her experience—for instance about the contraception they use—to other people. I think nowadays many people are educated well and therefore they can ask the right questions on contraception or other medical-related issues."* *"There are a lot of benefits. In the community such an active patient can be made a health cadre … if the patient is smart we can ask her to assist in our efforts to inform the community. A person like that would be consulted by the community."*

Table 24. Benefit of Active Community Leaders

West Java	Lampung
Active ToMa are needed in society because they can help people who are sick or patients. Beside that, since ToMa give people information, they have to be knowledgeable enough. According to participants, the benefit people received from that is long-term and constant. If FP becomes a successful program, then people's welfare will be increasing. In a more well off condition, people's health will be	They see leaders as a part of the health community and, because of that, should be able to provide general advice on health. A leader is also expected to care about health issues and to see to it that the community makes use of the health facilities and activities (such as Posyandu). Although not as explicit, the leaders share with the providers the tendencies to put the blame on the clients and to see that the obstacles to become a smart community

preserved and crime rate will be decreasing. As a result, children education will be more organized and juvenile delinquency rate will be declining. *"…don't let the country turn the promoting of FP into war…a war to diminish its population…Sometimes when you see children graduate from elementary school you ask yourself a question: where is this new generation going to take our country. People are jobless almost everywhere. FP reduce the crime rate if population is dwindling/ well-off economy/…but only those who join FP who will be prosperous…you see firstly, if [people] are healthy physically the environment will be inevitably healthy. So the leaders' role to improve welfare is somewhat easier to play. Secondly, there will be improvement in welfare since people are healthy they can do extra work which means improvement in manpower and economy/…for people in general, a successful FP resulting in a more organized education for children. Moreover, children who are raised in small families can have the benefit of better and higher education. The fathers' greater loving attention creates human characters sought after. The situation would be highly different from the above if the father is sick, the mother is sick, then the children are abandoned because they are too-many to control."* However, as admitted by them, being an active ToMa is not easy. One of obstacles they have to face is the lacking of the facility, high level of ignorant, their own needs, the difficulty in dividing time between their jobs and their titles as ToMa, the lacking of money, the lacking of knowledge and the difficulty in communicating. Meanwhile for ToMa, what they benefit from being active in society are knowledge enlargement and soul satisfaction. *"we acquired knowledge besides practicing our intelligence. We can get closer to society…to take them/ to make friends…in case we need their help/ soul satisfaction…[because we are] able to help/ it's our satisfaction to serve [people] voluntarily/…even if we are not paid for doing that we feel satisfied if the*	mostly come from the community members in general. Educational reasons to them seem to be the primary reasons why the community is not smart yet in their health seeking behaviour, although they also mentioned traditional values as something preventing the community to make optimal use of health care services. *"If the leaders are active and good obviously the community can see a model, "If he can do it, I should do it, too." So everything conveyed by the leaders can motivate the community. The community will also be proud of their leaders."* *"With such leaders I think the community will feel secured, they know that someone is looking after them."* They expect that community leaders provide examples of good health behaviour. They believe that the community will imitate such behaviours and that the leaders themselves would benefit from it because they will be seen as good leaders. This is not always an easy task because leaders are usually similar with their community on terms of their lack of knowledge about health. Still, they can demonstrate how they place health care and services high on their personal agenda.

society's improve its level of welfare and health." "The advantage for ToMa is the environmental safety. There will be decreasing juvenile delinquency because fewer children are easier to guide."	

CHAPTER FOUR: CONCLUSIONS AND RECOMMENDATIONS

WEST JAVA (KABUPATEN KUNINGAN)

Definition of Quality of FP Service Provision

Clients' Perspective	Providers' Perspective	Community Leaders' Perspective
The majority of clients think that the quality of FP service provision should be improved since patients still have to queue and stand in the crowd to get the service needed. In addition, The FP service provision is not always available everyday, which troubles the clients when they come the *puskesmas* to find out that the service in unavailable. Consequently, clients have to come to *puskesmas* again on the other day or see private or independent *bidan*. Besides that, *bidan* sometimes can not be seen in *puskesmas* because they are visiting the village. According to clients in Ciniru, *bidan* in *puskesmas* still get upset and grumble if clients come to complain. Furthermore, *puskesmas* sometimes run out of medicine so that the patients have to go to private *bidan*. According to clients, if they are active or clever enough they are able to look for alternative health-care service provision when service provision in *puskesmas* does not fulfill their need, for instance by seeing the private or independent *bidan.* Besides, if the clients are active it means that they already have understood that *bidan* is responsible for the placement of contraceptive device/the using of contraception, so if patients have something to complain they can take other patients to see the *bidan* referred to.	According to *bidan*, target aimed is no longer the quantity of FP acceptor but the improved quality of service provision instead. This condition might be achieved if recent manpower available is added to make the more effective service considering there are about 50 clients/patients come to *Puskesmas* everyday. Other than that, service provision will improve its quality if *bidan* and their apparatus follow the growth of knowledge. However, in reality this condition has not come to reality yet. Facilities provided such as medicine availability and consultation room influence quality of service provision. However, this problem still has not been able to overcome yet. Recently, the parameter of quality depend on *bidan*'s attitude toward client. Clients think the more relaxing *bidan'* attitude toward them, the better quality the service provision in *Puskesmas* is. In the discussion with *bidan* it is revealed that they do not agree if a good quality of service provision is merely *bidan* or health-care officer's responsibility. They actually expect that a client has already known the general outline	*ToMa'*s defined quality of FP service provision by referring to satisfaction of the service provided by *bidan* emotionally instead of referring to the completeness of facilities provided in *Puskesmas*. They assumed if the *bidan* has done her job according to the procedure and try to make clients feel comfortable, then the service is qualify enough.

A flexible relationship between the *bidan* and their clients enable clients to express openly their concerns. Parts of participants think that it is strange for a client who does not ask question/complain whenever she has specific complaints. Therefore, giving information without clients has to ask becomes an important **dimension/ thing/aspect**, especially to inform the parameter of success of the contraception used to the referred *bidan*. In other words, openness becomes important in getting advices to take further action in specific symptoms, such as specific wounds. Often, the condition that should be revealed to *bidan* is including hesitation so that *bidan* can support clients to make them feel assured.	of **information** about FP. A *bidan*'s tasks are to complete, to make sure or to guide the comprehension that has been formed. However, in reality, a *bidan* is very likely to feel upset or annoyed when seeing a client who often complains, especially thing that has nothing to do with the contraception, especially one who always complains something that has nothing to do with contraception usage, or a client who asks them all the time. It happens because they are not sufficient time to serve number of patients.	

Decision Making

Clients' Perspective	Providers' Perspective	Community Leaders' Perspective
To clients, the process of making decision to join the FP program is begun by collecting information from various sources, such as friends or neighbors. The information is very valuable for clients to know the purpose and the function FP program both for herself and her family. It is also important for preparing her to be able to express her complaints when the time has come. However, to guarantee the accuracy of the information she has gathered, a client usually asks opinion from PLKB, a formal and legal party. The role of the network or people around the client is important not only for making decision of joining the FP program but also for changing the contraception before they finally decide to see the *bidan* to get the service. The relationship made between clients and *bidan* make the process of changing contraception used	According to *bidan*, by giving sufficient information since the beginning, clients are able to predict specific side effects resulting from specific contraception used. Thus, before the technical of placement is done, *bidan* make sure once again whether clients are ready to make their decision. To *Bidan*, an absolute/ firm decision has to be mental requirement for an FP acceptor candidate. The function of a good *bidan* is to let	*ToMa* assumed that clients or patients are able to make decision in getting health-care service if they have knowledge not more than the *bidan* have. As clients, they have the privilege to complain to *bidan* freely and finally *bidan* are also expected to offer the right solution. Thus, two-way communication done by *bidan*

easier to do as quoted below: *" I said 'took it out right away ma'am, because it's time [to take the IUD out'], then [the bidan took it out]. 'On this date … it has to be placed again'. So we can take it out and placed it right away, it's easy…"* Most clients made sure that their husbands' opinion is a key factor in every decision made. A husband who thinks that having too-many children will be a burden for the family is an essential support for clients to decide to join the FP program. Moreover, options and advices from *bidan* are also factors that take part in the process of making decision by clients.	clients know all aspects of each kind of contraception, including its side effects. General check-up of health is also a prerequisite before the placement is done. Besides that, according to *bidan*, clients' decisions would not be considered firm enough if they were not supported by the closest member of family.	and clients play an important role.

Benefit gained by being proactive toward FP service provision

Clients' Perspective	Providers' Perspective	Community Leaders' Perspective
In general, the advantages clients have by being proactive are the expanding of experience and the increasing of knowledge, which broaden their horizon	Benefit gained by *bidan* if they are smart is the acknowledgment from clients so they can also be accepted by the surrounding society/people. It really depends on *bidan*' skill. The more increase their knowledge is the greater chance they will be an excellent *bidan* and the more accepted they would be by the society.	Benefit gained by ToMa for their active role are their increasing knowledge of health and the wider network they have so they will also broaden their horizon. In addition, society also has their own peace if children are clever, able to enjoy welfare, and able to avoid the juvenile delinquency.

LAMPUNG (KABUPATEN METRO)

Definition of Quality of FP Service Provision

Clients' Perspective	Providers' Perspective	Community Leaders' Perspective
Clients view quality in FP by relating it to the personal skill of provider to ease clients' anxiety, and to the existence of provider when needed. It is known also that decision-making is not a primary dimension that leads to a positive recollection of a service. Instead, they relate the service with aspects such as friendliness, quickness, and availability of providers. Comfort and attention to each personal needs and condition are also qualities that play role in clients' perspectives when defining the FP service	Providers see the quality of FP service as technically success they performed, such as: convincing clients to adopt, and mastering a new kind of, FP methods. Thus, it is clear that the dimensions of success are mostly one-way in which the providers feel that they are in control and they are doing their technical tasks well. Authority is of primary importance to the providers although they also mentioned being loved and respected is also important. Giving more leeway for the clients to choose is considered a requirement but is not something that they would consider a measure of success.	To the leaders, quality of service is mostly a question of access. They tend to think of good health care service in terms of the cost and availability to all community members. Free service and services affordable to all are the type of services these leaders tend to remember.

Decision Making

Clients' Perspective	Providers' Perspective	Community Leaders' Perspective
The clients indicate that ultimately they are the one who makes the decision, often with influence from their husband. Midwives can only offer explanation, advise towards one direction or another but the clients will decide based on what ever information they believes in and on the cost they can afford. So the issue is more with the quality of their information	Midwives always acknowledge the right of the client to make the ultimate decision, although in extra-ordinary case some of them ever inserted spirals into women without their consenting it. Midwives also indicate their significant roles in the client's decision-making process, for instance in cost as quotation below: *"….., we explain the affordable methods and explain their side effects. If we recommend implants while her socio-economic status is low that would just create a*	To most leaders, the issue of decision-making has a lot to do with the educational status of the community. Below is the quotation: *"In Metro, the community is urban, they are well educated… and educated people are smarter in making logical reasoning, and are more critical."* The leaders did not see how their own efforts could be

and selection made available to them rather than with the ultimate decision-making.	*problem."* The midwives also acknowledge the role of community leaders in convincing community to join FP or to use a certain method.	improved, perhaps because it is still unclear to them what their roles and responsibilities are in FP decision-making.

Benefit gained by being proactive toward FP service provision

Clients' Perspective	Providers' Perspective	Community Leaders' Perspective
According to the clients, the ideal clients would be a benefit to the community because healthy individuals can contribute better to the community welfare. They also see smart clients as helping the health care system to operate more expediently.	The midwives seem to be aware that many patients find it difficult to explain their own condition. In such occasions, the midwives would probe the patient more or sometimes attempt to judge their response. Midwives also see that it is their role to guide the clients to understand about their own body and its problems so that the proper diagnosis could be made.	The community leaders believe that if they could provide examples of good health behaviour, the community will imitate such behaviours and that the leaders themselves would benefit from it because they will be seen as good leaders.

OVERALL (WEST JAVA AND LAMPUNG)

As mentioned in the introduction that from the clients' perspective, quality in FP provision is seen as a matter of subjective opinions. It can be referred to a waiting time, the availability of service at the health centre (this also refers to the existence of providers), respect from providers (not upset or grumbling when received complaints from clients), openness and comfort in the relationship, as well as personal skill of providers.

However, smart is seen as a thing refers to cleverness that is very related to decision making to look for another health care service provision when the previous/received provision does not fulfil their needs. Here, smart is correlated to going to private midwife, while puskesmas is regarded as low/bad quality of service provision that served for common people (rakyat). Thus, it can be said that although FP service did not meet clients' expectancy, they have to receive the condition, or if they are smart enough (and supported by their financial condition) they will look for another providers.

From providers' point of view, quality is defined as technically success, the effectiveness of the relationship, and authority. Most bidan realized that they could not perform a good service in the puskesmas as they had to serve many patients. Therefore, in their opinion, health providers should be added in order to provide good service to clients. In the mean time, the present providers should also follow the scientific development. Bidan from West Java and Lampung both mentioned about support services such as logistics and other facilities provided in the puskesmas are also important to the quality of service provision. Nevertheless, no one of bidan

perceived clinical procedures (e.g. sanitary) was part of a smart clinical interaction. In other words, providers did not see clinical procedures as an aspect of quality.

In the Community Leaders' perspective, quality of FP service in West Java in general is defined as satisfaction of the service provided by providers and not merely to the facilities provided in the puskesmas. While in Lampung Community Leaders perceived quality in terms of cost and availability to all community members. To sum up, community leaders are not too much concern on FP program, first, because it is taking care by providers, and second, because they still consider FP program is women's domain while the majority of the community leaders are men.

In the decision making process of joining the FP program, clients used to gather information from their closed networks such as friends, neighbours or relatives. However, clients also stressed that the key element of every decision is their husbands. The role of providers in the decision making process is very low in both research areas.

RECOMMENDATION

From the results of FGD and in-depth interviews, it is clear that the term "smart" (translated as "cerdas") does not fit to describe either party: client, provider, and community leaders. In Bahasa Indonesia, "cerdas" means clever, quick-thinking, ability to get the better of others, or being faster or more decisive. Thus, the use of the term smart should be reviewed carefully. The term that could incorporate the characteristics desirable for the three parties: patient midwife, and community leader might be "wise" (translated as "bijak"), which include the feature of knowing what to do and how to behave in certain situations. In some group discussions, the term "model" (translated as "teladan") was also suggested which refers to behaviour that can be imitated.

It is apparent from the discussions that bidan feel they are targets of criticism. Much of what they say involves redirecting blame for perceived shortcomings in service. Program designers may find difficulty in facing with them when improving the quality of FP service. However, it is a consequence of development program: empowering clients means burning the providers. Thus, messages need to be carefully developed without lowering the midwives sense of authority and expertise.

Each party in the triangulation of client-midwife-leader does not know exactly what to do in such relationships. Leaders, for instance, are not very clear about what they could contribute to encourage clients to be "smarter." The first messages should, therefore, assist in providing guidelines as to how rights and responsibilities could be assigned. They could then be followed-up with messages that call to specific actions. This is a case where the awareness - that better family planning care for all is needed - is high but the stakeholders do not really know what to do - to make it better.

Eventually, both sides, clients and midwives, come to a conclusion that the Puskesmas service is appropriately of low quality. The clients have to go somewhere else too seek for a better health service, such as to private services or to the doctors. Only those without a better option would seek care in the Puskesmas. Apparently, this is a problem shared by public health service everywhere. Program designers have to be realistic in setting the goals and basing their programs to the defined quality of each community while gradually upping these levels to a universally acceptable one. Here, the roles of the community as a whole - and their leaders - are of more importance. Community would have more power and resources to ensure that the quality of family planning in their area is improved and that the lowest denominator should also receive acceptable treatment.

To a certain extent and through different expressions, all respondents show some attention towards the clients and, in particular the poor. However, most tends to see the clients more as an object or a target of the programs - or even as a problem. This is essentially an individual-blame approach, where solutions can primarily be found only at the clients themselves. Moreover, there are very few discussions about structural problems that can hamper clients from getting quality family planning care or impede midwives from providing one. Together as a community, these stakeholders need to be shown that clients are essential part of the solution but that they often face structural problems.

METHODOLOGICAL NOTES

The findings that midwives are often too quickly to shift the blame on the clients could, partially at least, is an artefact of the research settings. Whenever outside researchers come into an area the midwives feel that they are being evaluated, so the blame shifting might serve as a defence mechanism on the part of the midwives. The implication is that their very negative impressions about the clients should be carefully assessed to bring to light the truly amenable situations.

The execution of FGD was based on the coordination of STARH Program with BKKBN in the national, province, regency and district level. The selection of participants of FGD was conducted by the assistance of local PLKB officers, based on the criteria sent by the STARH Program. As the research team from Jakarta did not have enough time to do a field orientation, we have to receive all participants provided by the local BKKBN. As a consequence, the majority of clients' participants in Kabupaten Kuningan were cadres. This situation can influence the research findings as cadres have special relationship with bidan. However, the research team chose the informants for in-depth interview after each FGD session finished.

Finally, the selection of community leaders is not (indigenous) leaders of the community but they were structural power leaders. As a consequence, most participants are men. In many areas (even in urban areas), public domain is dominated by male while family planning is still regarded as female domain. Therefore, in the future, female community leaders should be involved in the research to listen to their better voice in FP program.